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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13903

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13916

1. DECEASED-NAME (Type or print)		First <i>Louis</i>	Middle	Last <i>Aaron</i>	2a. DATE OF DEATH 10 Month <i>14</i> Day <i>68</i> Year		2b. HOUR 10:50M								
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH 9/9/85		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <i>Balto</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.									
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore County General</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret. Conductor</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Trans</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>3504 Ellen Road</i>							
14. FATHER'S NAME <i>James Aaron</i>		First <i>James</i>		Middle <i>Aaron</i>		Last		15. MOTHER'S MAIDEN NAME <i>Jessie Courts</i>		First <i>Jessie</i>		Middle <i>Courts</i>		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i> (yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Mr. Henry H. Aaron</i>		Address <i>3504 Ellen Road 21207</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4109</i> IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i> DUE TO, OR AS A CONSEQUENCE OF <i>A.S.C.V.D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <i>6 yrs</i> (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1301</i>															
19a. DATE OF OPERATION <i>10/14/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>9/14</i> 19 <i>68</i> , to <i>10/14</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/14</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>M. J. Ellin M.D.</i>		22c. DATE SIGNED <i>10/14/68</i>		22d. PHYSICIAN'S NAME (Type) <i>M. J. Ellin</i>											
22e. ADDRESS <i>8629 Liberty Rd - Randallstown Md</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 17, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Frederick Ave. Balto Md.</i>									
24. FUNERAL DIRECTOR <i>Loring Byers</i>		ADDRESS <i>8728 Liberty Rd. Randallstown Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
JAMES		JOSEPH		ALUM		OCT. 13, 1968		2b. HOUR 10:45 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (to years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD
MALE	WHITE	11/20/92		75 YRS.	MONTHS DAYS HOURS MIN		OCTOBER 13, 1968		2d. HOUR 10:45 a.m.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
IRELAND		U.S.A.				BALTIMORE, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VETERANS ADMIN. HOSPITAL		PAINTER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE				140 E. CLEMENT STREET	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
WILLIAM		-		-		ALUM		ELIZABETH - - McKNIGHT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
YES		WWI		212 12 45 44		CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intake cerebral Hemorrhage - Left</u>									4 mos
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Frontal Paralysis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>9000</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>Alcoholism</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?					
8-2-68		He alone		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		AUG 1968		Full drunk driving + struck head					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
		AT HOME		140 E. CLEMENT ST., BALTO.,		307		MD.	
22a. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.B. Davis		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		M.B. DAVIS MD - Dundas		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City, town, or county)		10/13/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		10/14/68		HOLY CROSS CEMETERY		BALTIMORE, MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JAMES J. McCULLY FUNERAL DIR.,		130 E. FORT AVE., BALTO., MD.		DATE OCT 15 1968		J. Charles Judge			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the margin. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PW-3. Page 5 may be retained for your files.

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13907

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13918

1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			Month Day Year			21. HOUR			
RICHARD F. W. ALTE									Oct. 11 1968			12:30 AM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		22. DATE PRONOUNCED DEAD			2d. HOUR				
Male	White	6/5/1878	90	MONTHS	DAYS	HOURS	MIN.	Oct. 11, 1968			12:30 AM				
70. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Germany			USA						Baltimore						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Essex 21221			70 Silver Lane			Store-keeper			Store						
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Md.			Baltimore			Essex			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			70 Silver Lane			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
Unknown			Unknown												
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			214 22 6996			William Metzger			726 S. Marlyn Ave. 21221						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Acute cerebral vas accident</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
331X															
190. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
210. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)									
			HOUR A.M. P.M. 19												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County		State	
220. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED						
EXAMINER'S NAME (Type or Print)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			10/14/68						
Theodore Patterson						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
Theodore Patterson, M. D. 105 Main St. Dundalk, Md. 21222															
230. BURIAL, CREMATION, or other (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			10/14/68			Oak Lawn Cemetery			Baltimore, Md.						
24. FUNERAL DIRECTOR			ADDRESS			250. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Bruzdzinski Funeral Home			1407 Eastern Ave.			DATE OCT 14 1968			Charles Judge						

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EDWARD F. W. ALTH

Oct. 11, 1953

Oct. 11, 1953

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Oct 14 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13903

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13919

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MARJORIE S ANDERSON</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>12</b> Year <b>68</b>		2b. HOUR <b>6:40</b> AM
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>5.12.1916</b>		6. AGE (In years last birthday) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore County,</b> Md.		
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b> 13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>909 HARLEM AVE.</b>	
14. FATHER'S NAME <b>CHARLES F. REID</b>		15. MOTHER'S MAIDEN NAME <b>REMA HALL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <b>220-18-6908</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FAR-ADVANCED AUTONALY</b> <b>011.2</b> DUE TO, OR AS A CONSEQUENCE OF <b>Subarachnoid, Bulbar</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>0001</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10.7.1968</b> to <b>10.22.1968</b> , that (I) (we) last saw the deceased alive on <b>10.12.1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. Newcomer</b>		DEGREE ATTENDING <input type="checkbox"/> MED. <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED <b>10.12.1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		22e. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 16, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>	

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13902

CERTIFICATE OF DEATH

13920

1. DECEASED-NAME (Type or print) <b>Marie C. Andrews</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR M <b></b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Aug. 18, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Stoneleigh</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6603 Sherwood Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>6603 Sherwood Rd.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Jendrek</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Mary Jane</b> Middle <b>Carroll</b> Last <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or at unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-30-4720</b>		17. INFORMANT Address <b>John Q. Andrews 6603 Sherwood Rd. Balto., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1949</b> to <b>October 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>September 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles F. O'Donnell</b>				22c. DATE SIGNED <b>10/3/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>			
22e. ADDRESS <b>7501 York Road Balto., Md. 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>10/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</b>				25a. RECEIVED BY REGISTRAR DATE <b>OCT 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

05861

STATE OF TEXAS

1900

County of \_\_\_\_\_ State of \_\_\_\_\_

Know all men by these presents, \_\_\_\_\_

of the County of \_\_\_\_\_ State of \_\_\_\_\_

do hereby certify that \_\_\_\_\_

is the true and correct copy of \_\_\_\_\_

as the same appears from the \_\_\_\_\_

records of the \_\_\_\_\_

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. This certificate must be filed along with form PM-3. Pages 5 may be retained for your files.

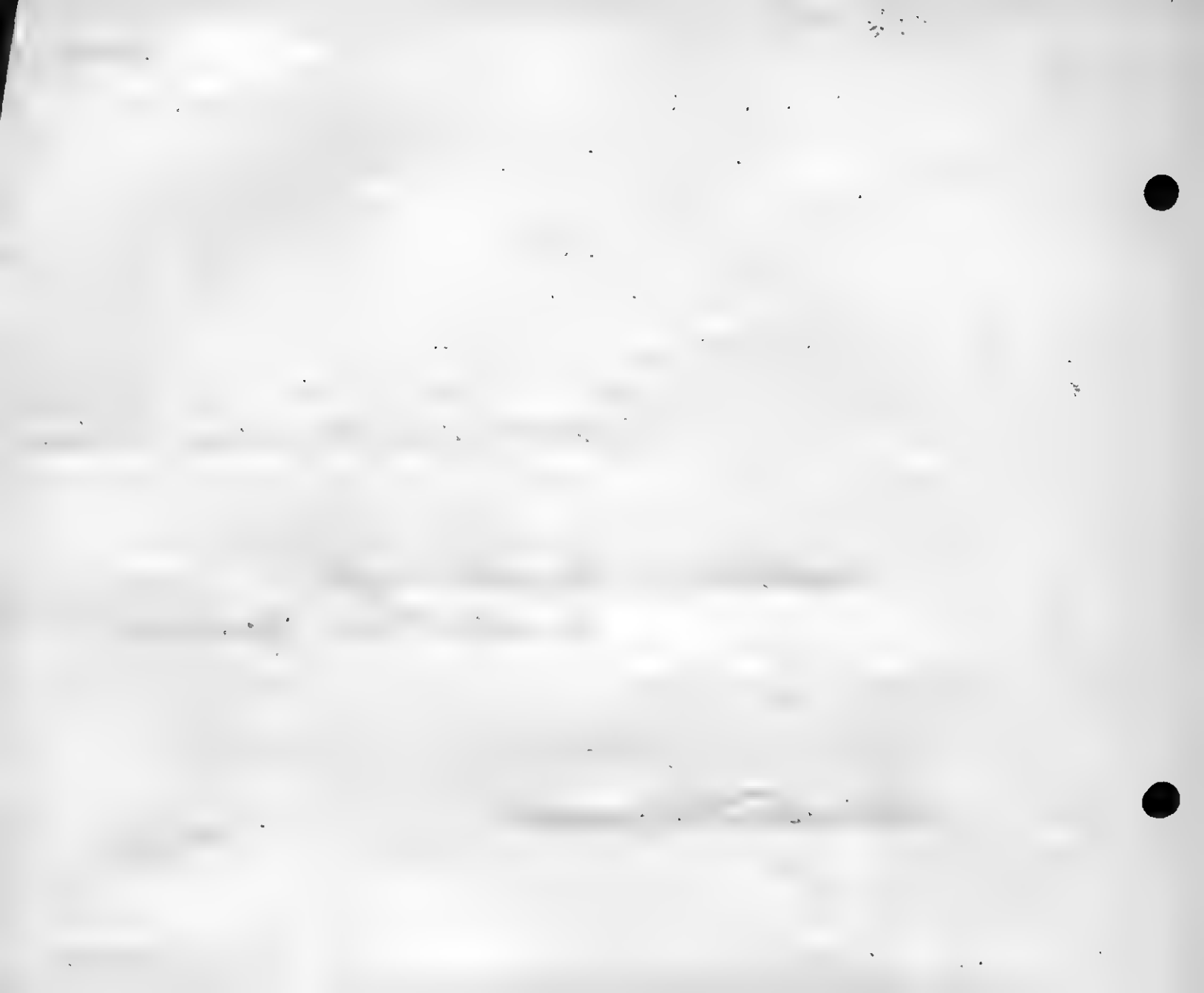
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13910

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13921

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year			2b. HOUR		
MELVIN F. BACK						Oct. 23 1968			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
male	white	2/4/1900	68 YRS					Oct 23 1968			M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Baltimore County			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph's						Western Elec		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Balto.			Parkville			2512 Taylor Avenue		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Adam John Back			Elizabeth Schmidt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215 10 4033			17. INFORMANT ADDRESS family records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Occlusion Sudden										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Insertion of Prosthetic Hip											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Crushed Hip of 20 yrs duration			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles Thorne			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 10/25/68					
23a. BURIAL, CREMATION REMOVAL (Specify) burial			23b. DATE Oct 26 1968			23c. NAME OF CEMETERY OR CREMATORY Parkwood			23d. LOCATION (City or Town) (County) (State) Parkville, Balto Md.		
24. FUNERAL DIRECTOR C. F. EVANS & SON 8802 Harford Rd.						25a. REC'D BY REGISTRAR DATE OCT 28 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13911

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13922

1. DECEASED NAME (Type or print) First Middle Last ETHEL I BAKER			2a. DATE OF DEATH Month Day Year Oct. 27 1968		2b. HOUR 7A M
3 SEX F	4. RACE W		5. DATE OF BIRTH July 21 1902		6. AGE (in years last birthday) 66
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Baltimore		12b. KIND OF BUSINESS OR INDUSTRY Uniforms			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Parkville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2901 Linganore ave.			
14. FATHER'S NAME First Middle Last James H. Wilson			15. MOTHER'S MAIDEN NAME First Middle Last Catherine R. Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-26-6201		17. INFORMANT Address Family records	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung (generalized)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RT Hemiplegia Diabetic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 10 1968</u> to <u>OCT 26 1968</u> , that (I) (we) last saw the deceased alive on <u>OCT 26</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jamshid Hamed M.D.</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Jamshid Hamed M.D.				22e. ADDRESS 204 E. Joppa road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
23d. LOCATION (City or Town) Baltimore, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON *** 8802 Harford Rd		25a. REC'D BY REGISTRAR DATE OCT 29 1968		25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>	

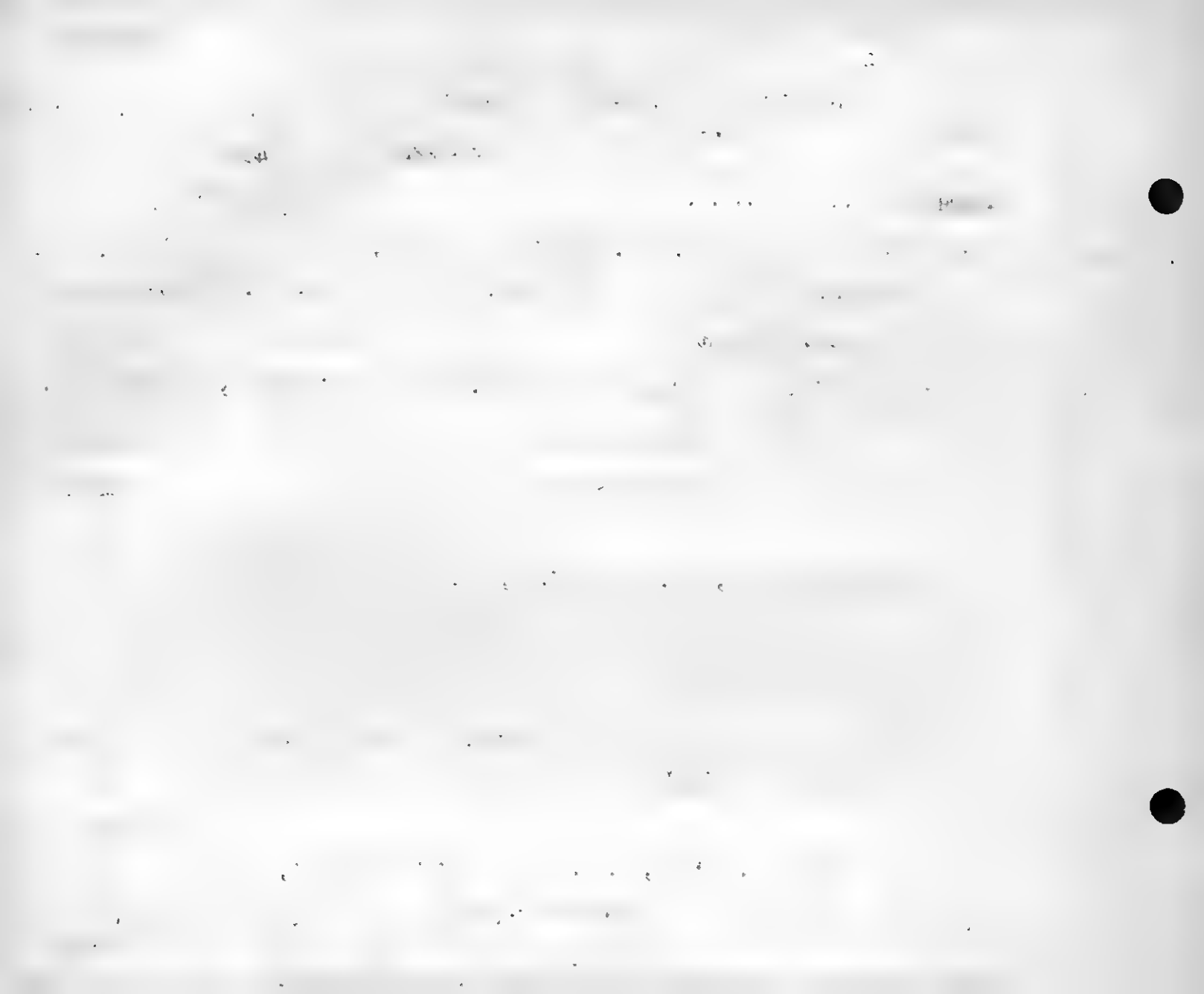


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 15-54  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print)			First <b>STANLEY</b>			Middle <b>VINSON</b>			Last <b>BAREFOOT</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>3</b> Year <b>68</b>			2b. HOUR <b>1:30AM</b>		
3 SEX <b>MALE</b>			4 RACE <b>NEGRO</b>			5. DATE OF BIRTH <b>12/25/24</b>			6 AGE (In years last birthday) <b>43</b> YRS.			7. F. UNDER 1 YEAR MONTHS _____ DAYS _____			8. F. UNDER 24 HRS. HOURS _____ MIN _____		
7a. BIRTHPLACE (State or foreign) <b>NORTH CAROLINA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md								
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>VEI. ADM. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PRESSER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>TAILOR SHOP</b>								
13a. US. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>2006 W. Fayette Street</b>					
14. FATHER'S NAME First <b>Linwood</b>			Middle <b>Barefoot</b>			Last <b>Barefoot</b>			15. MOTHER'S MAIDEN NAME First <b>Bertha</b>			Middle <b>Moore</b>			Last <b>Moore</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO <b>WW 11</b>			17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>												<b>RECENT</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>163x</b>												DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA, LEFT LUNG</b>					
												DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PULMONARY EMPHYSEMA, MARKED BILATERAL, OLD</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____											
22a. I certify that <b>1</b> (this hospital) attended the deceased from <b>8/18/68</b> , 19____, to <b>10/3/68</b> , 19____, that <b>1</b> (we) last saw the deceased alive on <b>10/3/68</b> , 19____, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) <b>not</b> view the body after death.																	
22b. SIGNATURE <b>Erhard J. Bunyor M.D.</b>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10/3/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>ERHARD J. BUNYOR, M. D.</b>			22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10-7-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>								
24. FUNERAL DIRECTOR <b>J.R. Bailey, Jr.</b>			ADDRESS <b>KELSON FUNERAL HOME</b>			25a. REC'D BY REGISTRAR <b>OCT 4 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								
						DATE <b>Baltimore, Md.</b>											





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

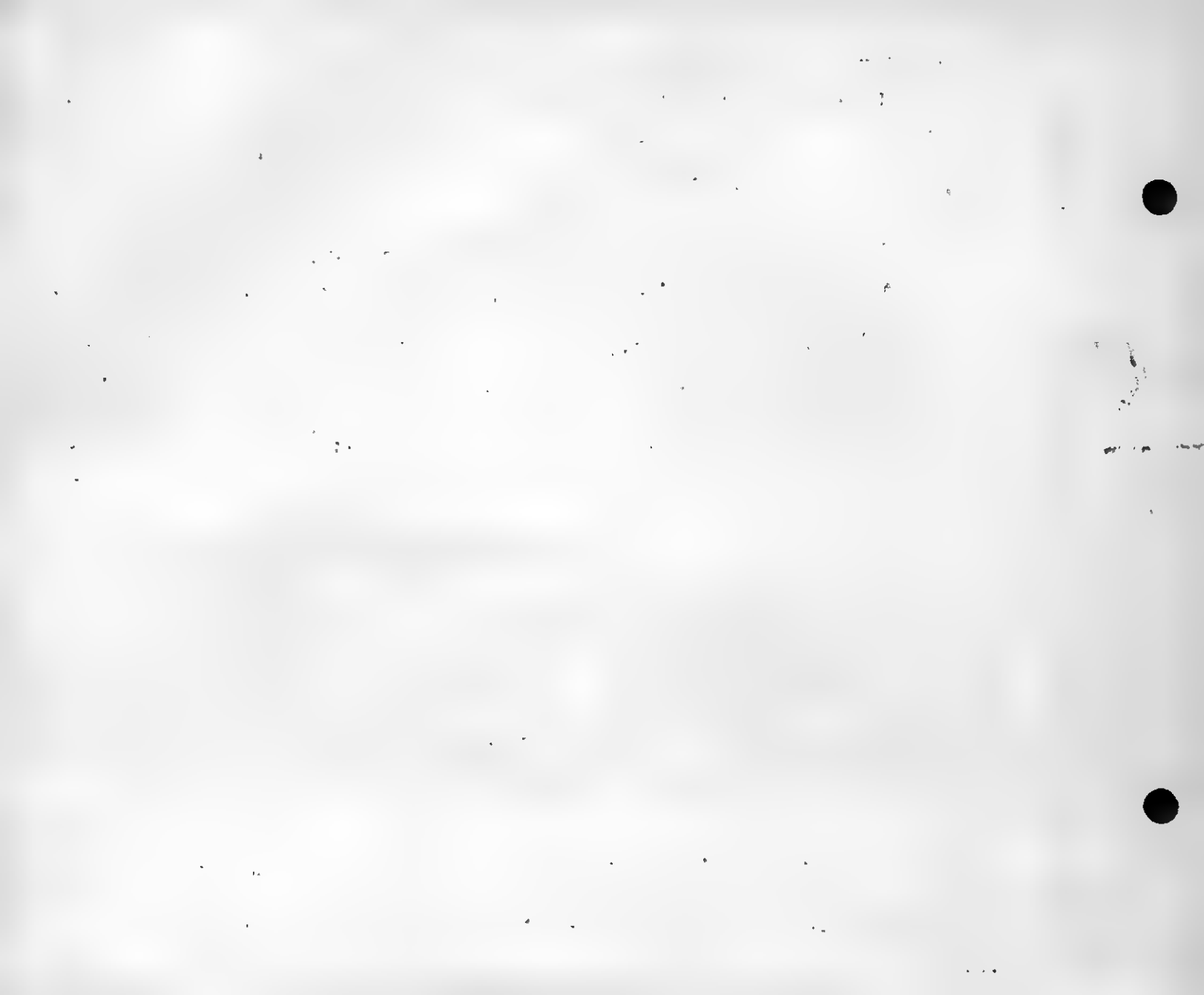
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13913

CERTIFICATE OF DEATH

13924

1. DECEASED-NAME (Type or print) <b>THAD OTIS BARNES</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>1:40</b> MIN <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>2-27-1907</b>		6. AGE (In years last birthday) <b>61</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b>	
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mount Wilson State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>334 W. Biddle Str.</b>							
14. FATHER'S NAME First <b>CARY</b> Middle <b>BARNES</b> Last <b>BARNES</b>			15. MOTHER'S MAIDEN NAME First <b>BELLE</b> Middle <b>DELOATCH</b> Last <b>DELOATCH</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>224-09-7680</b>		17. INFORMANT Address <b>Medical Records, Mt. Wilson State Hosp.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-24</b> , 19 <b>67</b> , to <b>10-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <b>W Newcomer</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-9-1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				22e. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 14 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CARVER CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SUFFOLK VA.</b>	
24. FUNERAL DIRECTOR <b>CHARLES R. LAY</b>				ADDRESS <b>802 WILSON AVE</b>		25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Louis</i>			First <i>(Lee)</i> Middle <i>A</i> Last <i>Basford</i>			2a. DATE OF DEATH Month <i>Oct</i> Day <i>6</i> Year <i>68</i>			2b. HOUR <i>11:45</i> P <i>M</i>		
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>12-26-95</i>		6. AGE (in years lost birthday) <i>72</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>BALTIMORE</i>		
10. CITY OR TOWN OF DEATH <i>RANDALLSTOWN</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>BALTIMORE CO. GEN. HOSP</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if instit on Res dence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>2002 MOSBY AVE</i>		
14. FATHER'S NAME <i>GEORGE M. BASFORD</i>			First <i></i> Middle <i></i> Last <i></i>			15. MOTHER'S MAIDEN NAME <i>Mary J. SPECHT</i>			First <i></i> Middle <i></i> Last <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>			16b. SOCIAL SECURITY NO <i>214-209-78</i>			17. INFORMANT <i>Col. H. M. Basford</i>			Address <i>2002 Mosby Rd</i>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cerebral thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF <i></i> (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>CA of Prostate &amp; Metastasis</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>9-16</i> , 19 <i>68</i> , to <i>10-6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-6</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Boon Vanasin</i>						DEGREE ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>Oct 6, 68</i>		
22d. PHYSICIAN'S NAME (Type) <i>BOON VANASIN</i>						22e. ADDRESS <i>Balta County General Hosp</i>					
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>Oct 9, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>			23d. LOCATION (City or town) (County) (State) <i>Balta Md.</i>		
24. FUNERAL DIRECTOR <i>Loring Byers Funeral Service, 8728 Liberty Rd.</i>						ADDRESS <i>Randallstown, Md. 21119</i>			25a. REC'D BY REGISTRAR DATE <i>OCT - 9 1968</i>		
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
30M REV. 1-64

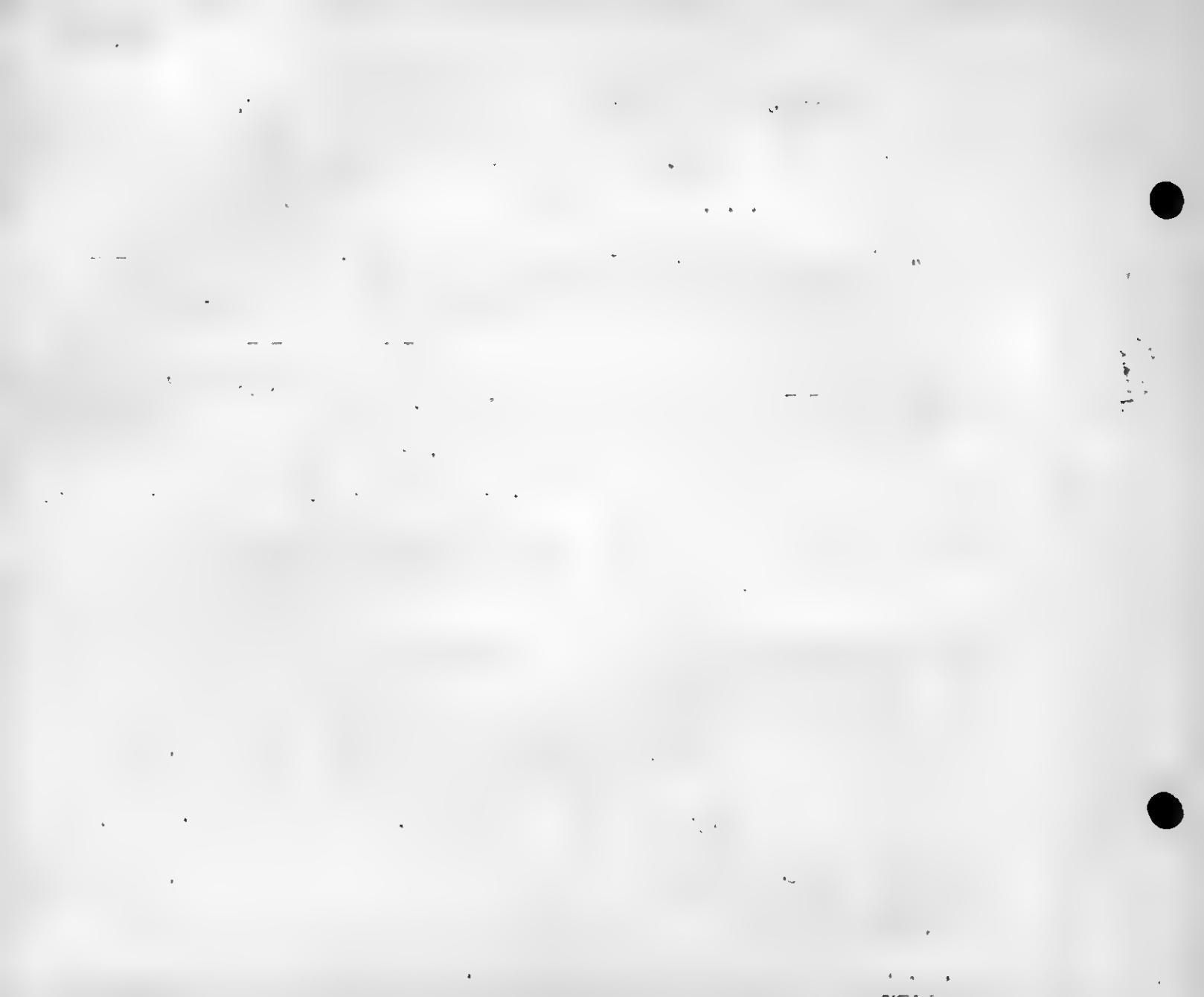
13915

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13926

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Margaret Basile</b>			2a. DATE OF DEATH Month <b>OCT.</b> Day <b>4</b> Year <b>68</b>		2b. HOUR <b>6 A.</b>
3 SEX <b>Female</b>	4 RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>8 OCT 1897</b>		6 AGE (In years last birthday) <b>70</b> YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Italy</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore,</b>		
10 CITY OR TOWN OF DEATH <b>Catonsville</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>House in the Pines</b>	12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIM TST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>8222 Scotts Level Road</b>	
14 FATHER'S NAME First <b>UNKNOWN</b> Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last <b>--- --- Termine</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>---</b>		16b. SOCIAL SECURITY NO. <b>216 10 6318A</b>	17 INFORMANT <b>Baltimore, Maryland 21201</b> <b>Mrs. Mary Iovenstein 8222 Scotts Level Road</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bronch - Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio - Sclerosis CV Disease 10 yrs.</b> (b) <b>2 mths</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>422: Urinary tract infection 3 mths</b>					
19a. DATE OF OPERATION <b>None</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDINGS, ETC.	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1</b> , 19 <b>68</b> , to <b>10/4</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>10/4</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Maurice Feldman</b>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>Maurice Feldman</b>		22e. ADDRESS <b>6610 Cross Country Blvd.</b>		22c. DATE SIGNED <b>10/5/68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Burial 7 Oct 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>J. E. Lowell Lemmon</b>		ADDRESS <b>4611 Park Heights Ave.</b>	25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





CERTIFICATE OF DEATH

13927

13916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>FRANK</b>		First <b>G.</b>		Middle <b>BASKETTE</b>		Last		2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>2:37A</b> M	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 10, 1907</b>			6. AGE (In years last birthday) <b>61</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>			Md		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Floorman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BETH. STEEL</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>6701 ROBERTS AVE. #21222</b>				
14. FATHER'S NAME First <b>James</b> Middle <b>R.</b> Last <b>Baskette</b>		15. MOTHER'S MAIDEN NAME First <b>Ninnie</b> Middle <b>Sauders</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>213-07-6122</b>		17. INFORMANT (Wife) <b>Mrs. Bessie G. Baskette, 6701 Roberts Ave.</b>		Address <b>Dundalk, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>49dx</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cor pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diffuse pulmonary emphysema and fibrosis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>October 20, 1968</b> , to <b>October 21, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 21, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>J. Cilliani</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/21/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13917

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13928

1 DECEASED NAME (Type or print) <b>VINCENT</b>		First <b>J.</b>	Middle <b>BATTAGLIA</b>	2a. DATE OF DEATH Month <b>10</b> Day <b>31</b> Year <b>1968</b>	2b. HOUR <b>10:35 PM</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>1/11/1908</b>		6. AGE (In years lost birthday) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>New York N.Y.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Cockeysville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>10304 Malcolm Circle</b>	
14. FATHER'S NAME First Middle Last <b>Salvatoria Battagalia</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Peppena Lodota</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (If ever, give dates of service) <b>W.W.II</b>		16b. SOCIAL SECURITY NO. <b>082 01 8972</b>	17 INFORMANT <b>Hospital Records</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic bronchogenic carcinoma</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1621</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>10/19</b> , 19 <b>68</b> , to <b>10/31</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>10/31</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles C. Brown, M.D.</b>		DEGREE <b>DEGREE</b>	ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>11/1/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Brown, M. D.</b>		22e. ADDRESS <b>Greater Baltimore Medical Center</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Mausoleum</b>	23b. DATE <b>Nov. 4, 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>William Cook-Brooks Towson, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



1  
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VR A15  
30M REV 10-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

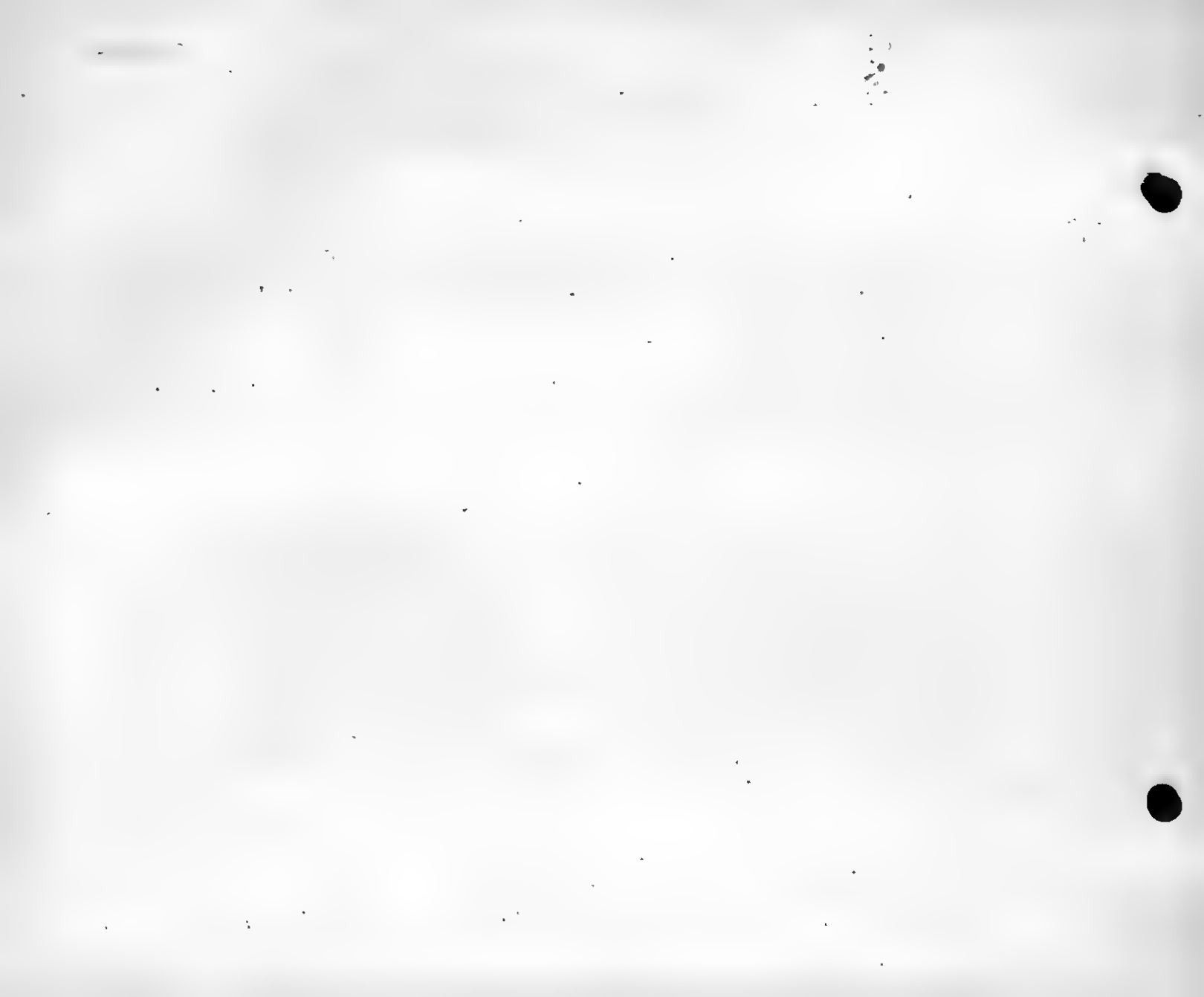
13919

CERTIFICATE OF DEATH

13929

1 DECEASED-NAME (Type or print) First Middle Last Douglas Wesley Baugher			2a DATE OF DEATH Month Day Year 10 27 68			2b HOUR 5:30 P M					
3 SEX Male		4 RACE White		5. DATE OF BIRTH 1/28/51		6 AGE (In years last birthday) 17 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH Owings Mills			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b KIND OF BUSINESS OR INDUSTRY none		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Carroll		13c CITY OR TOWN Union Bridge		13d INSIDE CITY (M.F.S.) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Route #2		
14 FATHER'S NAME First Middle Last Harry D Baugher			15. MOTHER'S MAIDEN NAME First Middle Last Golie H Marsh								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. none		17 INFORMANT Address Rosewood Records Owings Mills, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> 3459 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Spastic quadriplegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Epilepsy</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> , 19 <u>68</u> , to <u>10-27</u> , 19 <u>68</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>10-27</u> , 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.											
22b SIGNATURE Massoud Kaye						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 10-28-68		
22d PHYSICIAN'S NAME (Type) MASSOUD KAYE						22e ADDRESS Rosewood State Hospital, Owings Mills Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/30/68		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEM. WESTMINSTER, MD		23d. LOCATION (City or Town) (County) (State) Westminster, Md.					
24 FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.						25a REC'D BY REGISTRAR DATE NOV 1 1968		25b REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
hours Morgan Beall SR.						OCTOBER 24 1968			1:20 AM
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
MALE		White		6-12-99		69 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MD.			USA					Baltimore Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown			Baltimore County Gen.			Groceryman		Grocery	
13a. U.S. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD			Balto			Woodlawn		6500 Lehnert St	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Beall			Lora Newmire						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT		Address	
None			219-28-4128			Chart		Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 BRONCHOPNEUMONIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from OCT 13, 1968, to OCT 24, 1968, that (I) (we) last saw the deceased alive on OCT 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Fausto Q. Aquino Jr						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/24/68	
22d. PHYSICIAN'S NAME (Type) FAUSTO Q. AQUINO JR						22e. ADDRESS BALTO. COUNTY GEN. HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			10-28-68		WOODLAWN		WOODLAWN MD		
24. FUNERAL DIRECTOR'S NAME (Type) Francis W. Miller 2101 Rudwick Ave						25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items#13c&eFilm#G407 12/4/68 v m CERTIFICATE OF DEATH

13931

1 DECEASED NAME (Type in full) First Middle Last <b>13920 IRA Ronald Beatty</b>			2a DATE OF DEATH Month Day Year <b>10 2 68</b>			2b HOUR <b>4:10 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>aug 17, 1891</b>		6 AGE (In years last birthday) <b>77 YRS</b>	
7a BIRTHPLACE (State or foreign country) <b>MD.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b>	
10 CITY OR TOWN OF DEATH <b>Cockeysville</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Bonnie Blinks MASONIC HOME</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Burkittsville</b>		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14 FATHER'S NAME First Middle Last <b>AL Fred Beatty</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>MARY Fauble</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			
16b SOCIAL SECURITY NO. <b>219-20-0719</b>		17 INFORMANT Address <b>MASONIC HOME</b>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4109 Coronary artery occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4xvi</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 1965</b> to <b>Sept 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>8/2/68</b> 1968, and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE <b>JAMES HED HAMED MD.</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type) <b>JAMES HED HAMED MD.</b>		22e ADDRESS <b>Cockeysville, MD. Masonic Home</b>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>10-4-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>McOlivet Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Frederick Md</b>	
24 FUNERAL DIRECTOR <b>Wm. C. Bertsch</b>		ADDRESS <b>1050 York Rd. Towson Md 21204</b>		25a REC'D BY REGISTRAR <b>DA OCT 7 1968</b>		25b REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13821

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13932

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Annetta M. Becker						October 31 1968						M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR					
Female	White	July 6, 1920	48 YRS	MONTHS	DAYS	HOURS	MIN	October 31 1968	35 A.M.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH					
BALTO. MD.			U.S.A.			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Baltimore Co. MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			St. Joseph's Hosp.			Secretary			Lumber Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS DE CITY LIMITS?			13e. STREET AND NUMBER		
MD.			Calo.			Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12 Lyndale Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Louis Becker			Lydia Schilpp											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
No			212-18-5020			Mrs. Lydia Postluszny			42 Lyndale Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulatory Intake of</u> DUE TO, OR AS A CONSEQUENCE OF <u>Poison.</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4108</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			19 P.M.											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.			22b. DATE SIGNED <u>10/31/68</u>											
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
						ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			11-4-68			Parkwood Cemetery			Baltimore, Maryland					
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John C. Miller Inc-6415 Belair Rd.-21206									DATE NOV 6 1968			J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTIN DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13933			
13922													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Martin		Middle M. (Benedik)		Last Benedict		2a DATE OF DEATH Month Day Year October 24, 1968		2b HOUR 10:25 a.		
3 SEX male		4 RACE white		5. DATE OF BIRTH Oct. 15, 1899			6. AGE (In years last birthday) 69 YRS.		7c UNDER 1 YEAR MONTHS DAYS		7d UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore Md					
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Montgomery.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER none				
14. FATHER'S NAME First Middle Last Anthony Benedict					15 MOTHER'S MAIDEN NAME First Middle Last Mary Puscnik								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 382-01-6298T		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease, arteriosclerosis</u> (c) <u>diabetes</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Empty stomach - Diabetes Mellitus</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State									
22a. I certify that (x) (this hospital) attended the deceased from <u>Nov. 29</u> , 19 <u>61</u> , to <u>Oct. 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Rafael H. Marin</u>				DEGREE M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 10-24-68			
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-25-68		23c. NAME OF CEMETERY OR CREMATORY Greenbury Cemetery		23d. LOCATION (City or Town) (County) (State) Greenbury, Penn.							
24. FUNERAL DIRECTOR Forley, Carnegie & Co. - Catonsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13934

1 DECEASED-NAME (Type or print) First Middle Last Vernon M Benner			2a. DATE OF DEATH Month Day Year October 30 1968		2b. HOUR 12:00 PM
3. SEX M	4 RACE W	5. DATE OF BIRTH 12-30-05		6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Datto. Co. Gen. Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Brick Layer	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY --	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 534 South Bentalow	
14 FATHER'S NAME First Middle Last Frank Benner		15 MOTHER'S MAIDEN NAME First Middle Last Martha Tiepman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) No		16b. SOCIAL SECURITY NO 217-03-5698	17 INFORMANT Mrs. Eleanora M. Benner 534 S. Bentalow St. 21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4120 Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.					YEARS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4432					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 10-30, 19 68, to 10-30, 19 68, that (I) (we) last saw the deceased alive on 10-30, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Angela T. Paine		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 10-30-68	
22d. PHYSICIAN'S NAME (Type) ANGELITA T. PAINE		22e. ADDRESS BC 817			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-2-1968	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

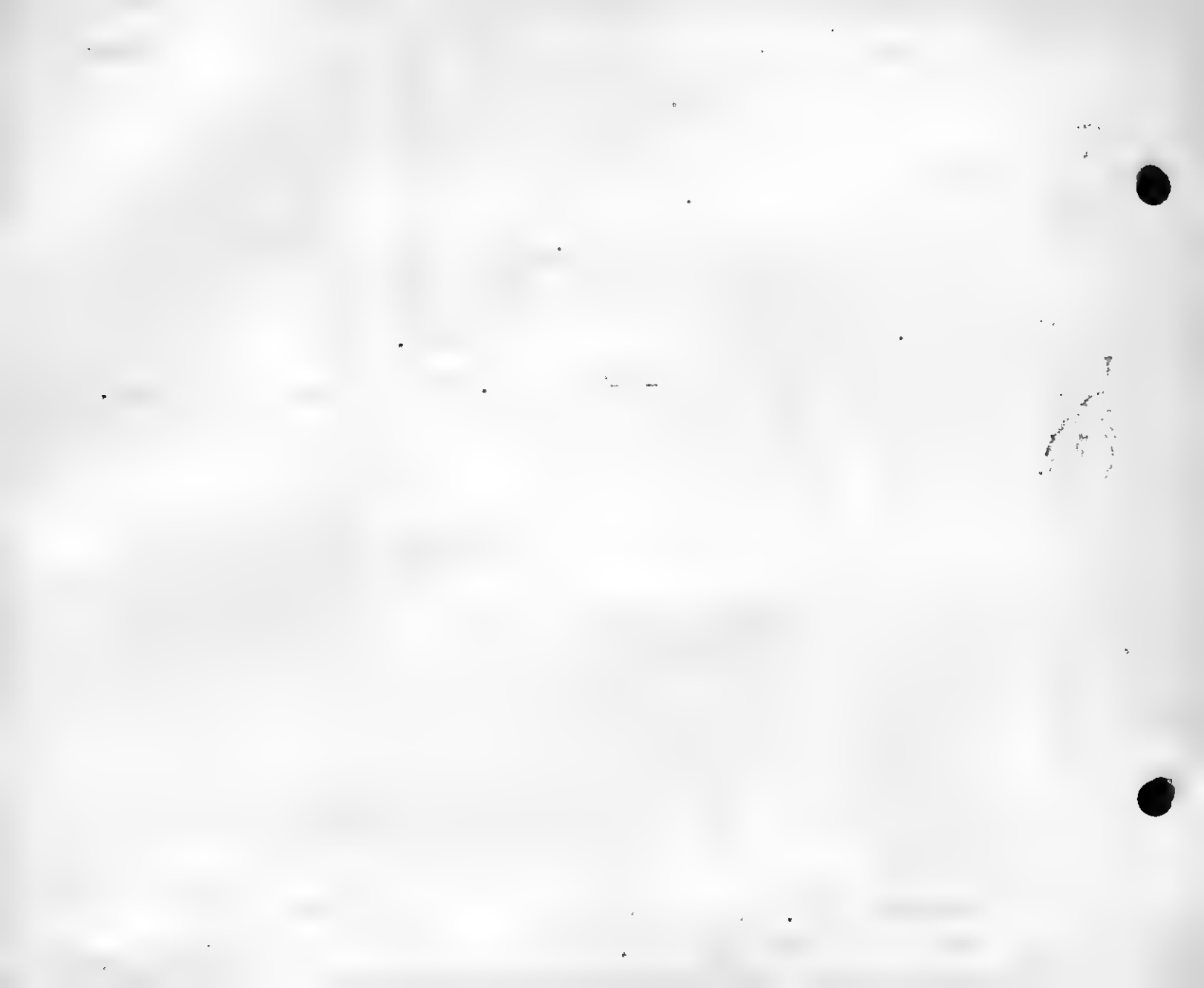
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13924

CERTIFICATE OF DEATH

13935

1. DECEASED-NAME (Type or print) <b>Oliver C. Benton</b>			2a. DATE OF DEATH <b>10</b> Month <b>15</b> Day <b>68</b> Year		2b. HOUR <b>7pm</b> M.
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>10-27-04</b>		6. AGE (In years lost birthday) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore County</b> Md.		
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Balto. Co. Gen. Hosp</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Sears</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>	13b. CITY OR TOWN <b>Balto</b>	13c. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Deer Park Road</b>		
14. FATHER'S NAME First Middle Last <b>Wm. Oliver Benton</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Lucy V. New</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO <b>298-05-3748</b>	17. INFORMANT Address <b>Mrs. Isabel Lee Benton Deer Park Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5901</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEPATICOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James C. Reed, M.D.</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>10-15-68</b>
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	23b. DATE <b>Oct. 18, 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Spring Cemetery, Bel</b>		23d. LOCATION (City or Town) (County) (State) <b>Belair Maryland</b>	
24. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. Randallstown</b>		25a. RECEIVED BY REGISTRAR <b>OCT 18 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13923		CERTIFICATE OF DEATH						13936	
1. DECEASED-NAME (Type or print) <b>EVELYN</b> <b>ROSE</b> <b>BERRY</b>					2a. DATE OF DEATH <b>10</b> Month <b>6</b> Day <b>1968</b> Year			2b. HOUR <b>5:40</b> AM	
3. SEX <b>F</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>18-Aug-1908</b>		6. AGE (In years last birthday) <b>60</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County, Md</b>			
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD</b>			13b. COUNTY <b>FREDRICK FREDERICK</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>ST. HANSON APTS W 6th ST.</b>	
14. FATHER'S NAME <b>FRANK</b> <b>JOSHUA</b> <b>HALL</b>			15. MOTHER'S MAIDEN NAME <b>MARGARET</b> <b>STELLA</b> <b>DORSEY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>UNKN</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEUTE LIVER FAILURE</b> <b>5/11/8</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>POST NECROTIC Cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>16 Dec</b> , 19 <b>66</b> , to <b>6 Oct</b> , 19 <b>68</b> , that <del>the</del> (we) last saw the deceased alive on <b>6 Oct</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>the</del> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William Newcomer</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6 Oct 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>					22e. ADDRESS <b>Mount Wilson, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		23d. LOCATION (City or Town) (County) (State) <b>Mt. Airy Fred</b>			
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Frederick, Md</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23 Film 406 11/6/68 W		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13937	
13926		CERTIFICATE OF DEATH			
1 DECEASED-NAME (Type or print) Donald Eugene Bianconi		First Middle Last		2a DATE OF DEATH 10-30-68 Month Day Year	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH Jan. 16, 1950	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (In years last birthday) 18 YRS.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7104 Eastbrook Ave.		9. COUNTY OF DEATH Baltimore Md	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b COUNTY Baltimore		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student	
13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 7104 Eastbrook Ave.	
14. FATHER'S NAME Charles Bianconi, Sr.		15. MOTHER'S MAIDEN NAME Ruth Belcher			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) None		17. INFORMANT Charles Bianconi, Sr., 7104 Eastbrook Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral mass</u> 11 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hodgkins Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. 5 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>20.1</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1964, to 10-29, 1968, that (I) (we) last saw the deceased alive on 10-12-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John B. Littleton</u>		DEGREE M.D.		22c. DATE SIGNED 10-30-68	
22d. PHYSICIAN'S NAME (Type) John B. Littleton		22e. ADDRESS 7104 Old Northpoint Rd. Balto. Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/2/1968		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore Balto. Md.		23e. REC'D BY REGISTRAR DATE OCT 31 1968		23f. REGISTRAR'S SIGNATURE O. Charles Judge	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.		ADDRESS			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13938							
13927 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First Lois			Middle Benson			Last Birmingham			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year Oct 1, 1968 8 PM					
3 SEX F		4 RACE W		5. DATE OF BIRTH Aug 25 1903		6 AGE (In years last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year Oct 1 1968 9 PM					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md								
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hosp. DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) At home			12b. KIND OF BUSINESS OR INDUSTRY -								
13a. USUAL RESIDENCE (Where deceased lived if admission) STATE Md			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4122 Roland Ave						
14. FATHER'S NAME First Middle Last Thomas J Benson			15. MOTHER'S MAIDEN NAME First Middle Last Bessie H. Burk			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-08-0137			17. INFORMANT Charles H. Birmingham					
16c. ADDRESS 4122 Roland Ave			18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221												19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County		State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED 10/1/68					
ACTUAL SIGNATURE Charles F. O'Donnell			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.			ADDRESS (Street, city, town, or county)														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/3/68			23c. NAME OF CEMETERY OR CREMATORY Woodlawn			23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto., Md								
24. FUNERAL DIRECTOR Burgee Funeral Home			ADDRESS 3631 Falls Rd			25a. REC'D BY REGISTRAR DATE OCT 7 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13828

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13939

1. DECEASED-NAME (Type or print)		First ANNA	Middle Margaret	Last BLEAKLEY	2a. DATE OF DEATH Month October		Day 26	Year 1968	2b. HOUR 1:30 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-12-1892		6. AGE (In years last birthday) 76 YRS.		7. IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN
7d. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3009 Acton Road 21234		
14. FATHER'S NAME First Charles		Middle Resch		Last		15. MOTHER'S MAIDEN NAME First Elizabeth		Middle Wolferman		Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-09-2565		17. INFORMANT Husband		Address Harry F. Sr.		Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary emboli 1560 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Gall Bladder with metastasis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 155										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 10-21, 19 68, to 10-26, 19 68, that (I) (we) last saw the deceased alive on 10-26, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Ines Giliatti MD		DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-26-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/29/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) Baltimore		(County)		(State) MD
24. FUNERAL DIRECTOR Chas. F. Evans Jr		ADDRESS 8802 Hardford Rd			25a. REC'D BY REGISTRAR DATE OCT 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove the body papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13922

CERTIFICATE OF DEATH

13940

1 DECEASED-NAME (Type or print)		First <b>CLARA</b>	Middle	Last <b>MAE BLOOM</b>	2a DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>1968</b>		2b HOUR M			
3 SEX <b>1</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>5-24-1858</b>		6 AGE (in years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>Calto, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Towson</b>			Md	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>McKeesville</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md</b>		13b COUNTY <b>Calto</b>		13c CITY OR TOWN <b>Towson</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>1026 Donington Circle</b>		
14. FATHER'S NAME First <b>Harry</b> Middle <b>W</b> Last <b>W</b>		15 MOTHER'S MAIDEN NAME First <b>Ann</b> Middle <b>Smith</b> Last <b>Smith</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO <b>4129</b>		17 INFORMANT <b>Clara B Segares</b>		Address <b>1026 Donington Circle Towson, Md 21204</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Left Ventricular Failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Heart Disease</b> <b>10 years?</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>20</b>										
19a DATE OF OPERATION <b>10-10</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>10-10</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>10-10</b>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that (I) (the hospital) attended the deceased from <b>10-10</b> , 19 <b>68</b> , to <b>10-13</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Keith A. Manley M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <b>10-14-68</b>				
22d PHYSICIAN'S NAME (Type) <b>KEITH A. MANLEY</b>		22e ADDRESS <b>2045, YORK ROAD. TIMMANY</b>								
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>10-17-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>PRUID RIDGE</b>		23d LOCATION (City or Town) (County) (State) <b>Tikesville MD</b>				
24 FUNERAL DIRECTOR <b>Wm Cook-Brooks Towson</b>		ADDRESS <b>1050 York Rd Towson, Md</b>		25a REC'D BY REGISTRAR <b>OCT 15 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

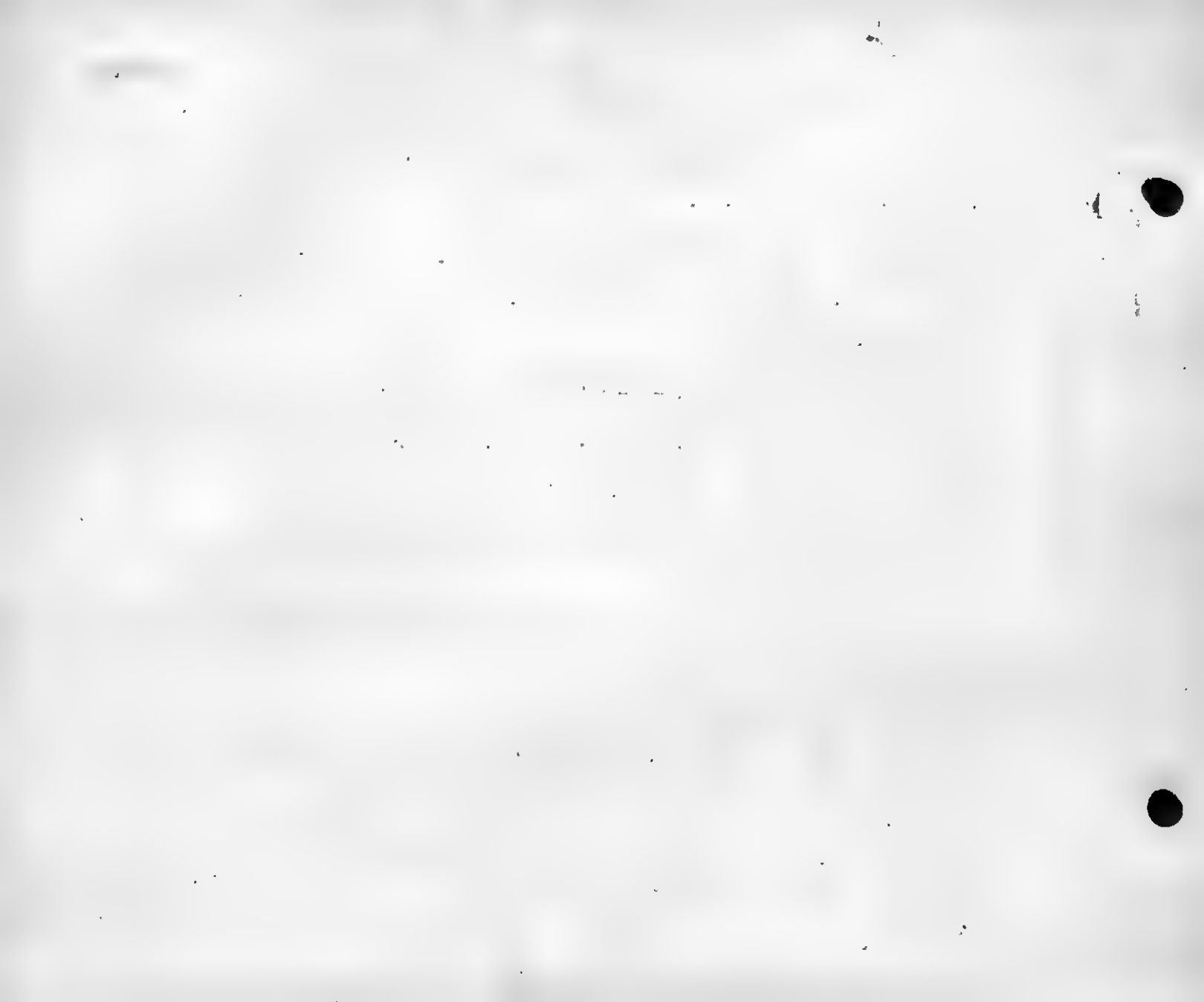
VR A15  
30M REV

13930

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Lucy May Bortner			2a DATE OF DEATH Oct Month 14 Day 68 Year 10 P M								
3. SEX female		4. RACE white		5. DATE OF BIRTH Aug. 10, 1892		6. AGE (In years lost birthday) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10 CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4527 Keswick Road		
14 FATHER'S NAME First Middle Last George Herndon			15. MOTHER'S MAIDEN NAME First Middle Last Aida Mack								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 212-03-3923		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary ulcer infected - DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 420											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1959, to 10-14, 1968, that (I) (we) last saw the deceased alive on 10-14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Vicente M. Ruelas MD						DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-14-68	
22d. PHYSICIAN'S NAME (Type) VICENTE M. RUELAS MD						22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-18-68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem		23d. LOCATION (City or Town) (County) (State) Woodlawn B2/H6 Md					
24. FUNERAL DIRECTOR Burgess Funeral Home B2/H6 Md						25a. REC'D BY REGISTRAR DA OCT 21 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-1  
30A REV. 1-7-68

13931

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13942

1. DECEASED-NAME (Type or print) First Middle Last <b>FRANCIS L. BOYCE</b>			2a. DATE OF DEATH Month Day Year <b>OCT. 22 1968</b>			2b. HOUR <b>2:15 P.M.</b>											
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>3-14-85</b>		6. AGE (in years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md											
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Summit Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TRANSFER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY - APTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>316 Martingale Ave.</b>									
14. FATHER'S NAME First Middle Last <b>GEO. BOYCE</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>KATE BULLOCK</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) (If yes give war or dates of service) <b>No</b>						16b. SOCIAL SECURITY NO.		17. INFORMANT <b>STANLEY F. BOYCE</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardio Vasc. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral Atherosclerosis</b>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 31, 1960</b> , to <b>Oct 22, 1968</b> , that (I) (we) last saw the deceased alive on <b>OCT 22 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Harry L. Knipp</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10-22-68</b>											
22d. PHYSICIAN'S NAME (Type) <b>HARRY L. KNIPP</b>		22e. ADDRESS <b>4116 Edmondson Ave. Balt Md. 2129</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE</b>		23d. LOCATION (City or Town) <b>BALTO. CO. MD.</b>		(County)		(State)							
24. FUNERAL DIRECTOR <b>E. S. MALNAB</b>				ADDRESS <b>361 FREDERICK AVE 21225</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

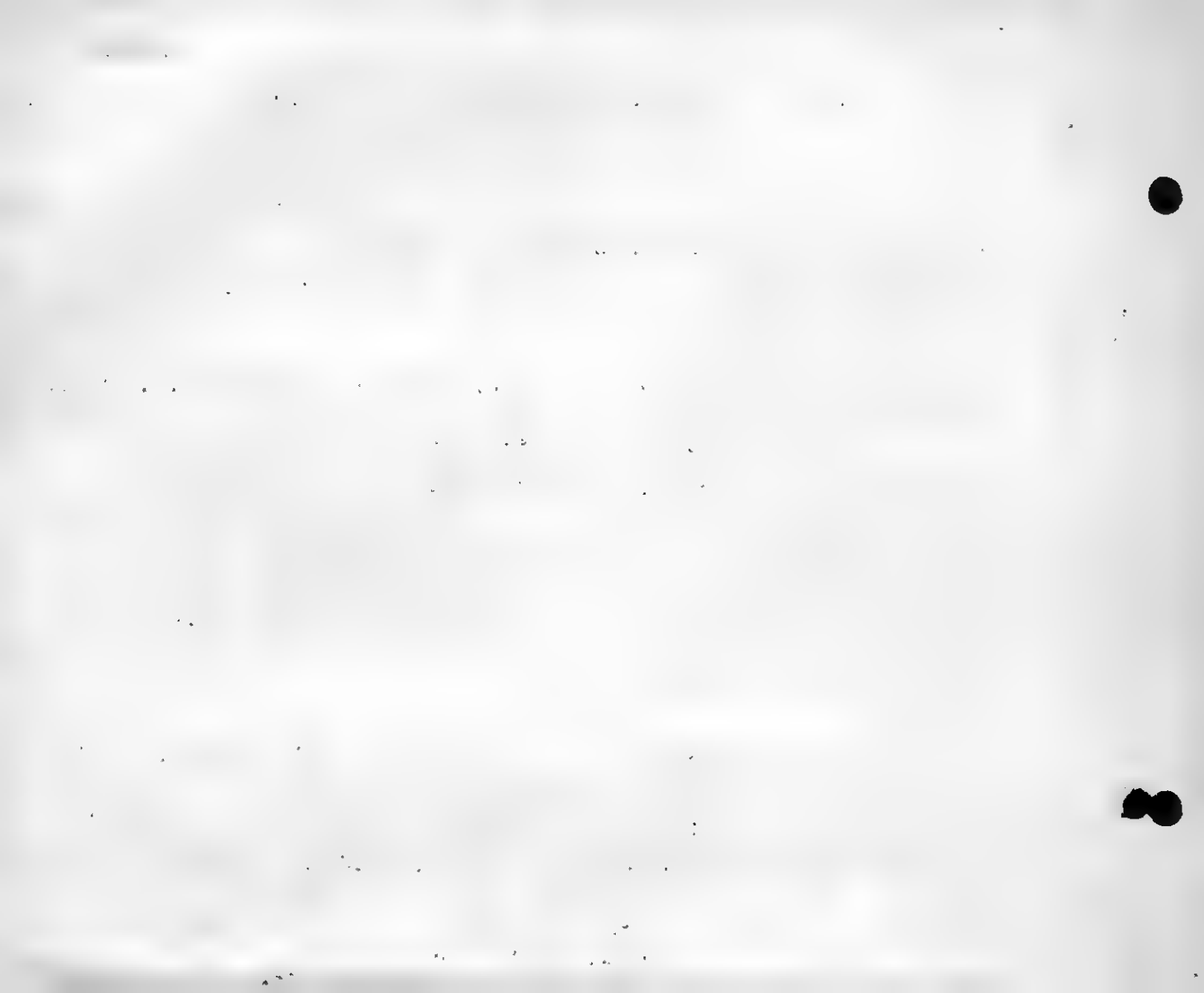
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12932

CERTIFICATE OF DEATH

13943

1 DECEASED-NAME (Type or print) <b>EDWARD</b>		First	Middle <b>N.</b>	Last <b>BOYER</b>	2a. DATE OF DEATH Month Day Year <b>OCTOBER 23 1968</b>		2b. HOUR <b>9:30A M</b>		
3 SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>11/20/98</b>		6. AGE (In years last birthday) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VEI. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>2601 Ulman Avenue</b>	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <b>YES WW I</b>		16b. SOCIAL SECURITY NO <b>217 07 25 72</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebral HEMORRHAGE</b> <b>4017</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>201X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l. medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>8/27/68</b> , 19____, to <b>10/23/68</b> , 19____, that <del>he</del> (we) last saw the deceased alive on <b>10/23/68</b> , 19____, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Irvin Carroll</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/23/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>INFAN A. ORER, M. D.</b>				22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>Irvin Carroll</b>				ADDRESS <b>HALSTEAD FUNERAL HOME</b>		25a. REC'D BY REGISTRAR DATE <b>1206 W. MORRIS AVE. BAL. MD. OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John G. Judge</b>	



FOR STATE  
HEALTH DEPT.

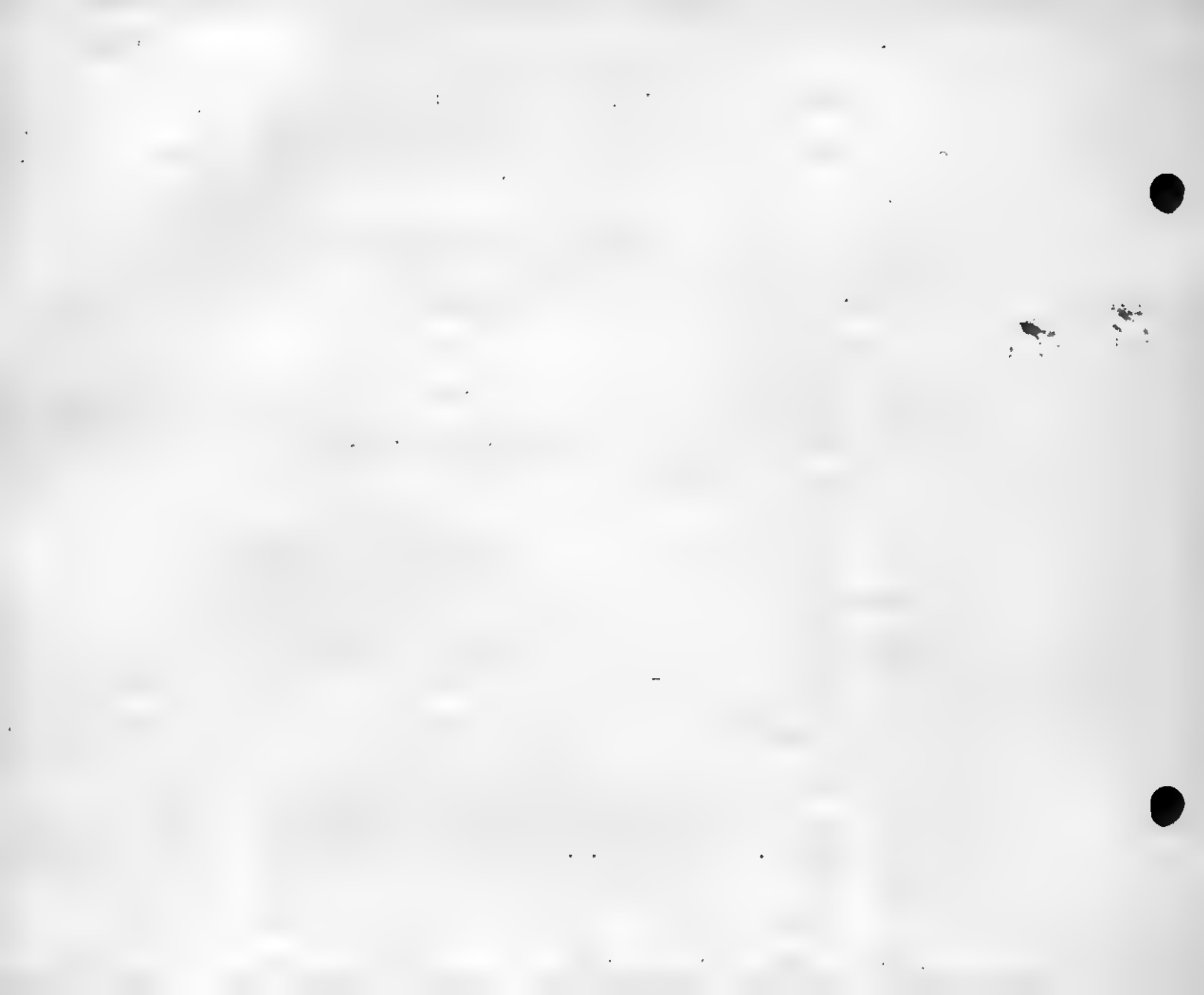
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 5 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13933

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13944

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
WILLIAM EDWARD BRADY					10-16				1968	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	Oct 9 1925	43 YRS			October 16, 1968				3:00 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				BALTIMORE				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Carney		2919 Ontario Ave		Drill Press Oper.		Koppers Co				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. HRS OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.		Baltimore						2919 Ontario		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
David Brady					Katherine Phillips					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
Yes.		WW2		219-22-8737		Family Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shotgun wound of mouth 955X DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. P.M. 10-16 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) basement		21f. LOCATION Street or R.F.D. No 2919 Ontario		City or Town Baltimore		County Md.		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MED CAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED October 17, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10-19-68		Parkwood Cem.		Baltimore Maryland				
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First A.		Middle STANLEY		Last BRAGER, SR.		2a. DATE OF DEATH Month Day Year OCTOBER 30, 1968		2b. HOUR 6 A. M.
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MAY 29, 1885		6 AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH PIKESVILLE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) INVESTMENT		12b. KIND OF BUSINESS OR INDUSTRY BROKER				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2601 MADISON AVENUE		
14. FATHER'S NAME First Middle Last ALBERT A. BRAGER		15. MOTHER'S MAIDEN NAME First Middle Last BLEMA FRIEDENWALD								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT MR. A. STANLEY BRAGER, JR., 7039 CONCORD RD. #8		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. 4-1-9 IMMEDIATE CAUSE (a) Arteriosclerosis, cerebral DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2-4-4 Carcinoma of larynx										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town. County. State						
22a. I certify that (I) (this hospital) attended the deceased from 10/26/68, to 10/30/68, that (I) (we) last saw the deceased alive on 10/26/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Alan Bernstein		22c. DATE SIGNED 10/30/68		22d. PHYSICIAN'S NAME (Type) ALAN BERNSTEIN		22e. ADDRESS 819 PARK AVENUE				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-31-68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR DATE OCT 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13935										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13946																																																																					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																																																																									
1 DECEASED NAME (Type or Print)					First					Middle					Last					2a DATE KNOWN OF DEATH					Month					Day					Year					2b HOUR																																																	
Mary					Sophie					Branigan										10-24-68					19					5:45 P.M.																																																											
3 SEX					4 RACE					5 DATE OF BIRTH					6 AGE (In years last birthday)					7 UNDER 1 YEAR					8 UNDER 24 HRS					2c DATE PRONOUNCED DEAD					Month					Day					Year					2d HOUR																																							
Female					W					5-30-81					87 YRS																				10					24					19					6:54 P.M.																																							
7a BIRTHPLACE (State or foreign country)										7b CITIZEN OF WHAT COUNTRY?										8 MARRIED										NEVER MARRIED										9 COUNTY OF DEATH																																																	
Maryland										U.S.A.										WIDOWED										DIVORCED										Baltimore Co.																																																	
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																																																											
Rosedale										1247 Neighbors Ave.										Cleaning Woman										Hospital																																																											
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE										13b COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIMITS?										13e STREET AND NUMBER																																																	
Md.										Baltimore										Rosedale										YES										NO										1247 Neighbors Ave.																																							
14 FATHER'S NAME										First										Middle										Last										15 MOTHER'S MAIDEN NAME										First										Middle										Last																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b SOCIAL SECURITY NO										17 INFORMANT										ADDRESS																																																											
no										213-18-1677										William H. Tudor										1247 Neighbors Ave.																																																											
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										PART 1. DEATH WAS CAUSED BY										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
4129										ACG HD																																																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																																									
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES										NO																																																	
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING										21b TIME OF INJURY Month, Day, Year										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																																					
CAUSE OF DEATH										HOUR A.M.																																																																															
										P.M.																																																																															
21d INJURY OCCURRED										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or R.F.D. No.										City or Town										County										State																																							
WHILE AT WORK										NOT WHILE AT WORK																																																																															
22a I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from:										Natural causes										Accident										Suicide										Homicide										Undetermined manner																																							
ACTUAL SIGNATURE										THEO C. PATTERSON										M.D.										CHIEF MEDICAL EXAMINER										ASSISTANT MEDICAL EXAMINER										DEPUTY MEDICAL EXAMINER										ADDRESS (Street, city, town, or county)										22b DATE SIGNED																			
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town)										(County)										(State)																																							
Burial										10-28-68										Zion Cemetery										Baltimore										Maryland																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE																																																											
										Philip E. Gwach										1211 Chesaco Ave										OCT 28 1968										Charles Judge																																																	

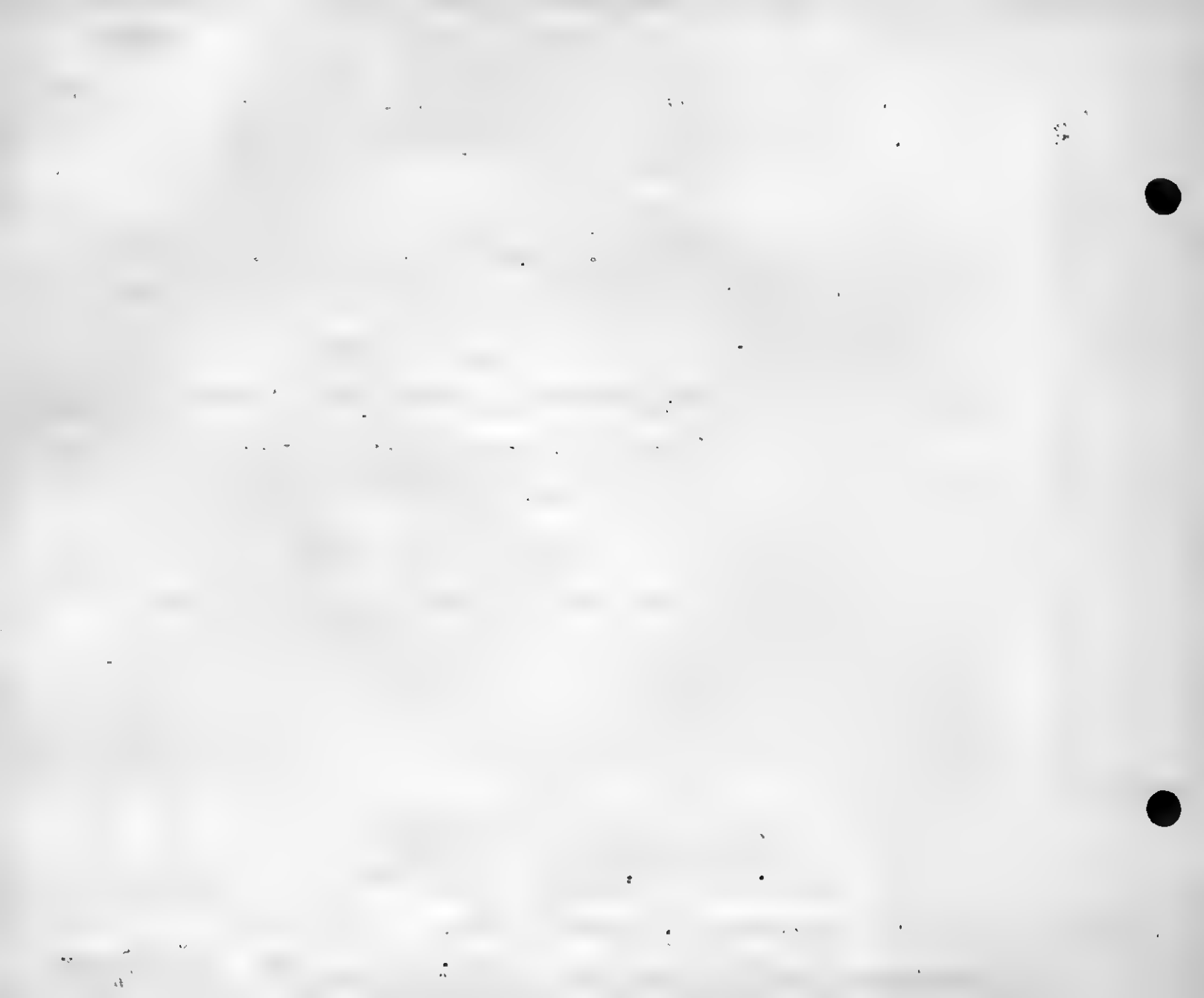


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13-41  
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
13936 CERTIFICATE OF DEATH 13947												
1 DECEASED NAME (Type or print) First Middle Last Robert Edward Brathuhn, Sr.						2a. DATE OF DEATH Month Day Year 10 10 68			2b. HOUR 6:30 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7/27/23			6. AGE (In years last birthday) 45 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A.-St. Josephs			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Police Sgt.			12b. KIND OF BUSINESS OR INDUSTRY Balto. City			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland			13b. CITY OR TOWN Baltimore			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4807 King Ave.				
14. FATHER'S NAME First Middle Last Grover C. Brathuhn				15. MOTHER'S MAIDEN NAME First Middle Last Estelle Clubb								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes			(If yes give war or dates of service) WWII			16b. SOCIAL SECURITY NO. 215-18-6778			17. INFORMANT Address Leora Brathuhn 4807 King Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>4 mos.</u>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> , 19 <u>68</u> , to <u>10-10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Wyman K. Wong, M.D.</u>						DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/12/68		
22d. PHYSICIAN'S NAME (Type) Wyman K. Wong, M.D.						22e. ADDRESS 6801 Belair Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/14/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214				25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

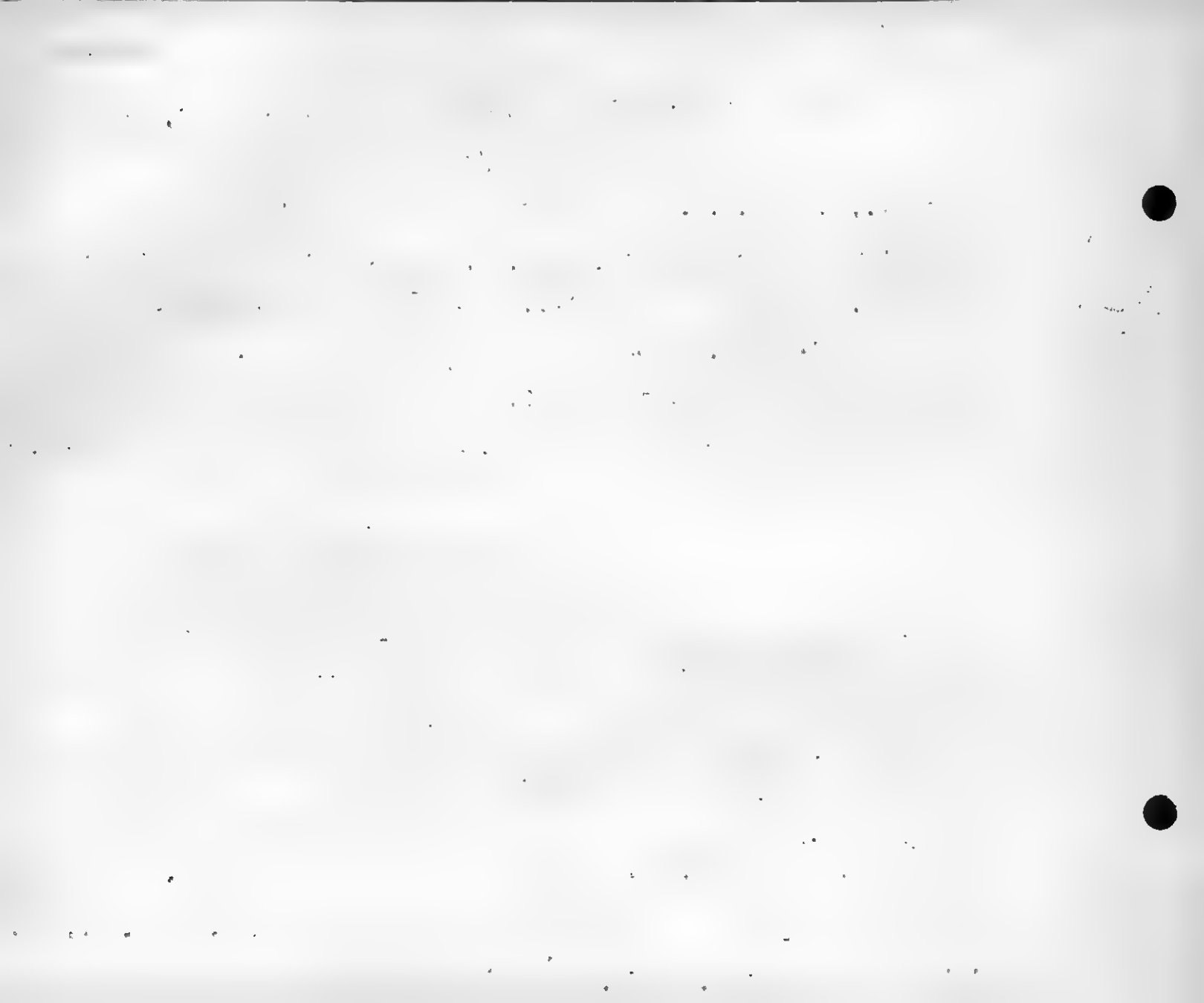
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>CATHERINE A. BREITENBACH</b>					2a. DATE OF DEATH <b>OCT 26 1968</b>		2b. HOUR <b>6:30 PM</b>		
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 5, 1874</b>		6. AGE (In years last birthday) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>HOOD NURSING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>LINTHICUM</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>FOREST VIEW ROAD</b>			
14. FATHER'S NAME First <b>JOHANN</b> Middle <b>MATTHIAS</b> Last <b>DEUTSCH</b>					15. MOTHER'S MAIDEN NAME First <b>KATHRINA</b> Middle <b>SCHAMANN</b> Last <b>MD.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MAY NEIGHOFF 584 FORREST VIEW RD LINTHICUM MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Senility</b>									Undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>440.9</b>									Undetermined
(b) <b>Arteriosclerosis Generalized</b>									Undetermined
DUE TO, OR AS A CONSEQUENCE OF (c)									Undetermined
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<b>Stroke</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>May 1956</b> , 19__, to <b>October 26 1968</b> , that (I) (we) saw the deceased alive on <b>October 26 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. A. Bradley Daugherty M.D.</b>				22c. DATE SIGNED <b>10-28-68</b>					
22a. PHYSICIAN'S NAME (Type) <b>Dr. A. Bradley Daugherty</b>		22b. ADDRESS <b>1264 Francis Avenue 21227</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE CITY, BALTIMORE MD.</b>			
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD</b> ADDRESS <b>4107 WILKENS AVE 21229</b>				25a. REC'D BY REGISTRAR <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 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636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Helen Virginia Briddell</b>					2a. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1968</b>		2b. HOUR <b>3:30 P.M.</b>		
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>12/8/1876</b>		6 AGE (In years last birthday) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b> Md.			
10 CITY OR TOWN OF DEATH <b>Towson 21204</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dulaney Towson N. H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>21210</b>		13d. INSIDE CITY, M.T.S? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>4403 Wickford Road</b>	
14 FATHER'S NAME First <b>William</b> Middle <b>H.</b> Last <b>Doste</b>					15 MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>C.</b> Last <b>Start</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-01-4793</b>		17 INFORMANT Address <b>C. Orville Briddell, (Same)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis (generalized)</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b>A.M.</b> Month <b>April</b> Day <b>4</b> Year <b>1968</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1957</b> to <b>October 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>October 11, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Grafton Hersperger</b> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10/14/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Grafton W. Hersperger</b>					22e. ADDRESS <b>Medical Arts Bldg.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>					ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13950

Item #13b,c,e, Film #406 11/22/68

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>OSCAR</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>10 22 68</b>			2b. HOUR <b>4:20 AM</b>		
3. SEX <b>MALE</b>			4. RACE <b>CAU</b>			5. DATE OF BIRTH <b>02-28-78</b>			6. AGE (in years last birthday) <b>90</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Millington Co., Queenstown</b>			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>BALTO. MD.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GRIN. BALTO. MEDICAL CENTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Queenstown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Vincent Briscoe</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Hensley</b>			13e. STREET AND NUMBER <b>Millington Co., Masonic Homes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO <b>214 28 3074</b>			17. INFORMANT Address <b>Masonic Homes, Cockeysville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE RENAL FAILURE</b> <b>47410</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DISSECTING ANEURYSM OF THE AORTA, DIABETES MELLITIS WITH POSSIBLY ACUTE ACIDOSIS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 DAYS</b>		
									<b>5 HOURS</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4517</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-08</b> , 19 <b>68</b> to <b>10-22</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-22-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>GIHAN TENNEKON</b>						22c. DATE SIGNED <b>10-22-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>GIHAN TENNEKON</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>Oct. 25, 68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>			23d. LOCATION (City or Town) (County) (State) <b>Hillsboro, Caroline Co., Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, Towson, Md.</b>						25a. REC'D BY REGISTRAR <b>OCT 23 1968</b>			25b. REGISTRAR'S SIGNATURE		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13940

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Merril Augustus Brooks			2a. DATE OF DEATH Month Day Year 10 28 08			2b. HOUR 2:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-30-89		6. AGE (In years last birthday) 19 YRS.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Restaurant Prop.		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 605 Church Lane 21207	
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Elizabeth Barrett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 214-32-2966		17. INFORMANT Mr. Carl F. Brooks, 3718 Courtleigh Dr. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Acute suppurative pancreatitis DUE TO, OR AS A CONSEQUENCE OF (c) <del>Old myocardial infarct</del> IUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days weeks to months - At least months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) OLD myocardial infarct - IUS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Simon Calle, MD				22c. DATE SIGNED 10/27/68		22d. PHYSICIAN'S NAME (Type) Simon Calle, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR DATE OCT 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A 156  
30M REV 1/68

13941

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13952

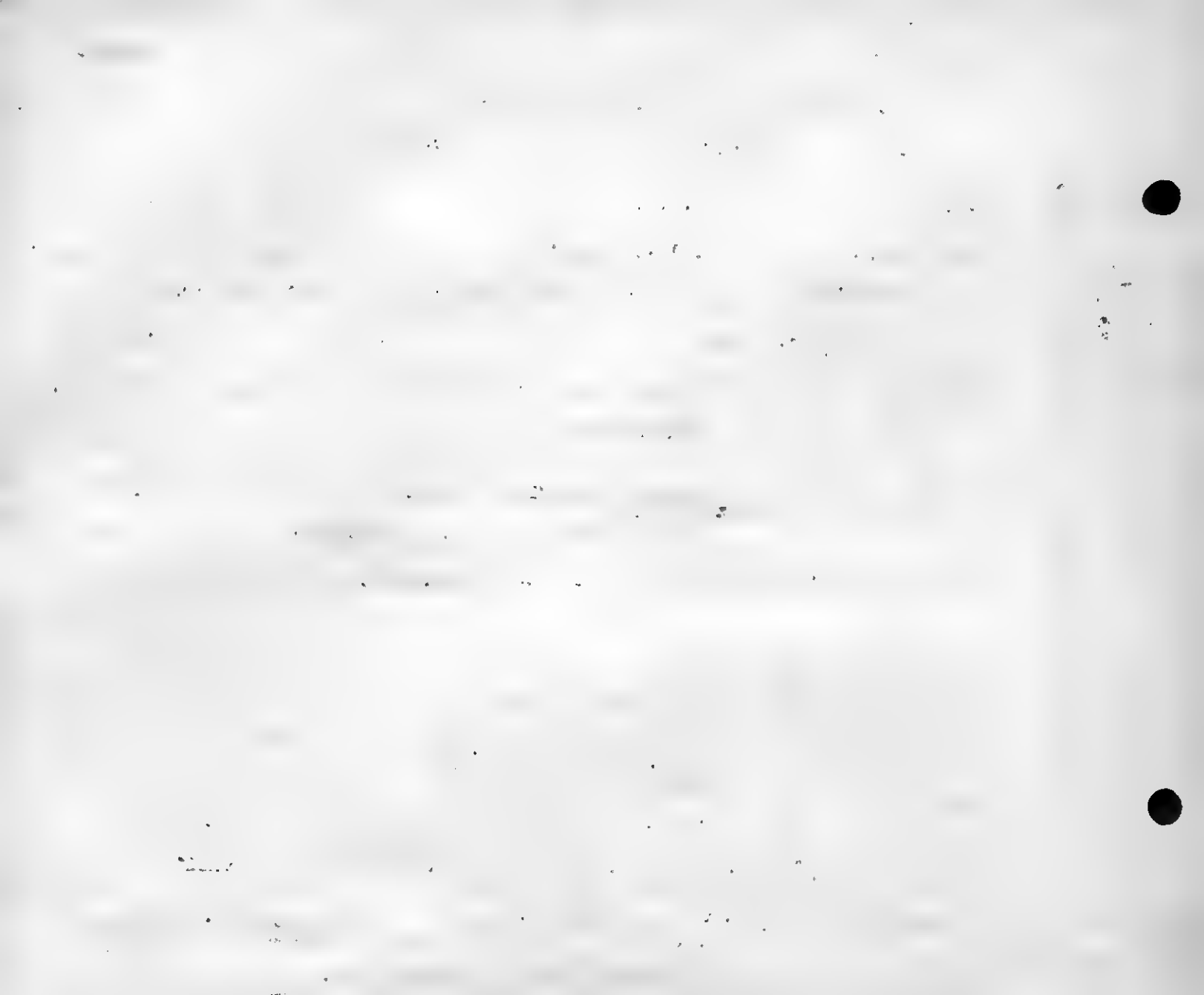
1. DECEASED-NAME (Type or print) Norman James Brosenne, Jr.			2a. DATE OF DEATH Month Day Year Oct. 16 1968		2b. HOUR 8:30 PM
3. SEX Male	4. RACE white	5. DATE OF BIRTH 12-29-1914		6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mount Wilson State Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Landscaper	
13a. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) STATE Md		13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. #3 Klees Mill Rd Sykesville
14. FATHER'S NAME First Middle Last Harry Brosenne		15. MOTHER'S MAIDEN NAME First Middle Last Mary E. O'Neill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 219-10-6243		17. INFORMANT Address Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>68</u> , to <u>10-10</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>Oct. 10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W Newcomer</u>				22c. DATE SIGNED 10-10-68	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/15/1968		23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Gardens	
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.		23d. LOCATION (City or Town) (County) (State) Carroll, Md.		25a. REC'D BY REGISTRAR DATE OCT 15 1968	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10842		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH		13953					
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
CHARLES		H.		BROWN				Month 10		Day 17		Year 68	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		6/29/95		73 YRS.		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
MARYLAND		U.S.A.				BALTIMORE COUNTY,						Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
FORT HOWARD		VET. ADM. HOSPITAL		SHOE SALESMAN		SHOE COMPANY							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND		Baltimore		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		616 Cooks Lane					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle Last	
WILLIAM H. BROWN								SARA				CAMPBELL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
YES		WW I		212 01 36 32		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
		BRONCHOPNEUMONIA,				DAYS							
		PULMONARY EMPHYSEMA, MARKED				YEARS							
		ARTERIOSCLEROSIS MARKED, GENERALIZED				OLD							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		BENIGN PROSTATIC HYPERTROPHY, OLD.		ENCEPHALOMALACIA, LEFT CEREBRUM, OLD									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from 6/26/68, 19, to 10/17/68, 19, that (I) (we) last saw the deceased alive on 10/17/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED							
PETER V. JUVAN						10/17/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
PETER V. JUVAN, M. D.		VAH FORT HOWARD, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
BURIAL		10/21/68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND							
24. FUNERAL DIRECTOR		WITZKE FUNERAL HOME		25a. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
		EDMONDSON AVENUE, BALTIMORE, MD.		OCT 18 1968									



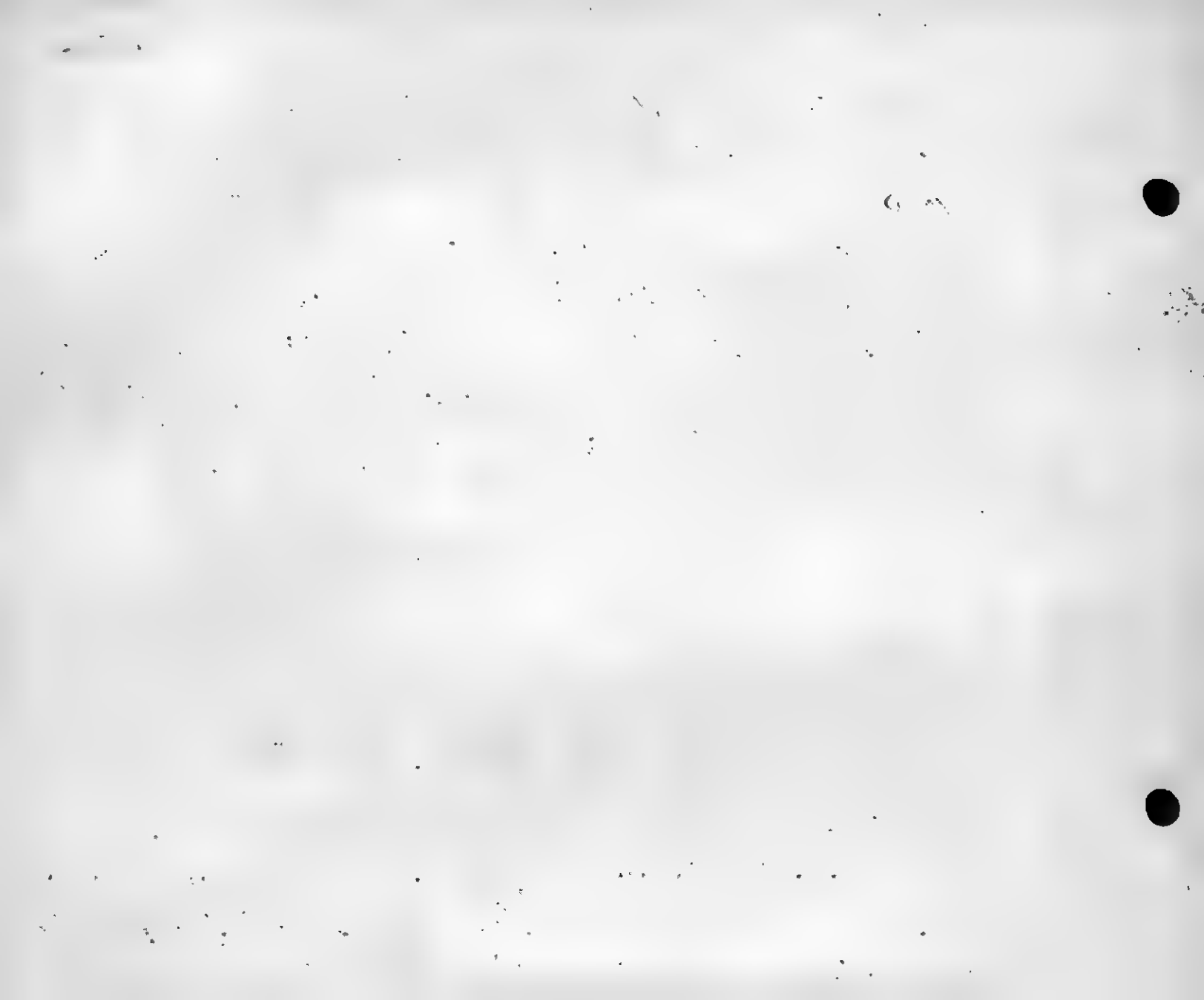


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-4  
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
NELLIE			BROWN			10 Month 6 Day 68			7:30 PM				
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		
F		NEGRO		4/2/83			85 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
MD.		U.S.A.				BALTO. Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON				HARVEY PA. AVE				HOUSEWIFE				HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MD				BALTO		TOWSON		YES		421 E. PA. AVE.			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last				
Jarline			Smith			Elizabeth			Morgan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT			Address				
no				none		Margaret Brown			421 E. Pa. Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC HEART DISEASE													
4129 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.			21f. LOCATION			Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from 3/15/56, 1956, to 10/6/68, 1968, that (I) (we) last saw the deceased alive on 9/25/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED				
T. C. Siwinski									Oct. 7, 1968				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
T. C. Siwinski, M.D.			206 W. Pennsylvania Ave., Towson, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial		10/9/68		John Wesley				Abingdon Harford Co. Md.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR											
Chas. L. Chaturian		25b. REGISTRAR'S SIGNATURE											
		OCT 10 1968											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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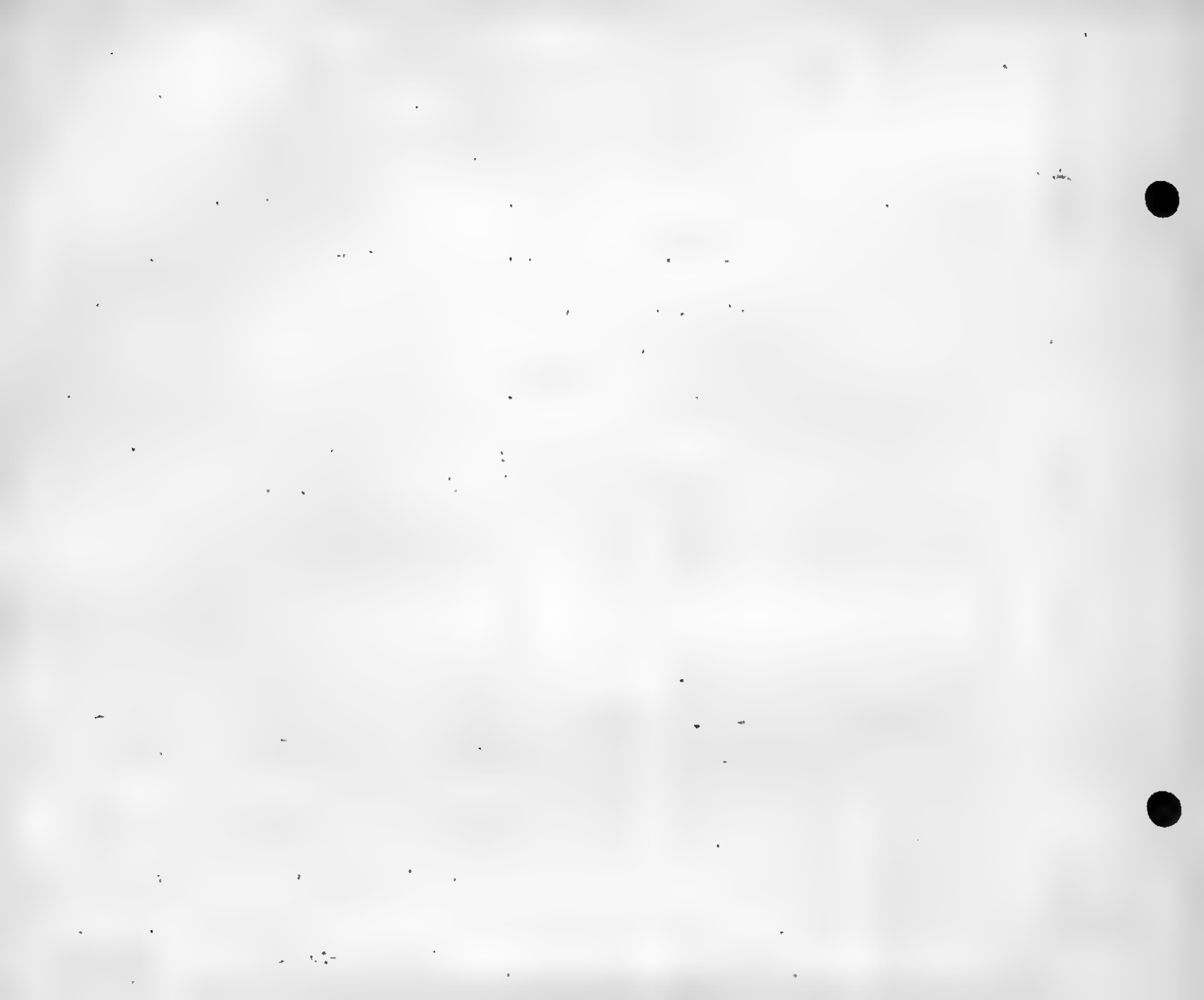
13844

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13955

# CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <u>Evelyn</u> First <u>Evelyn</u> Middle <u>—</u> Last <u>Buell</u>		2a DATE OF DEATH Month <u>October</u> Day <u>13</u> Year <u>68</u>		2b HOUR <u>6:30</u> AM	
3. SEX <u>FEMALE</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>8-14-1895</u>	6 AGE (in years last birthday) <u>73</u> YRS	IF UNDER 1 YEAR MONTHS <u>—</u> DAYS <u>—</u>	IF UNDER 24 HRS. HOURS <u>—</u> MIN <u>—</u>
7a BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	7b CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Baltimore County</u> Md		
10 CITY OR TOWN OF DEATH <u>Towson</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Ches. Manor Nurs. Home</u>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Presser</u>	12b KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>	13b COUNTY <u>Baltimore Co.</u>	13c CITY OR TOWN <u>Baltimore</u>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <u>1699 Kirkwood Rd. 21207</u>	
14. FATHER'S NAME First <u>Belt</u> Middle <u>—</u> Last <u>—</u>	15. MOTHER'S MAIDEN NAME First <u>Rachel</u> Middle <u>—</u> Last <u>—</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)	16b SOCIAL SECURITY NO <u>220-05-3708</u>	17 INFORMANT Address <u>T. Richard Buell, 1699 Kirkwood Rd.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF <u>Perforated Pyloric Ulcer with Surgery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF <u>—</u> (c) <u>—</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2 1/2 Mo</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>5401</u>					
19a. DATE OF OPERATION <u>8/1/68</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Perforated Pyloric Ulcer</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes (Surgical)</u>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>19</u> P.M. <u>—</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>—</u>			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) <u>—</u>	21f LOCATION Street or R.F.D. No. <u>—</u> City or Town <u>—</u> County <u>—</u> State <u>—</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 30, 1968</u> , to <u>October 13, 1968</u> , that (I) (we) lost the deceased on <u>October 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>W. Grafton Hensperger</u>	DEGREE <u>—</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>10/14/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>W. Grafton Hensperger</u>	22e. ADDRESS <u>Ra. 214 Medical Arts Bldg.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 16, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Carroll County, Md.</u>		
24. FUNERAL DIRECTOR <u>Nitzke Fun. Dir., 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 15 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 11 and 12 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 10-1-68  
30M REP

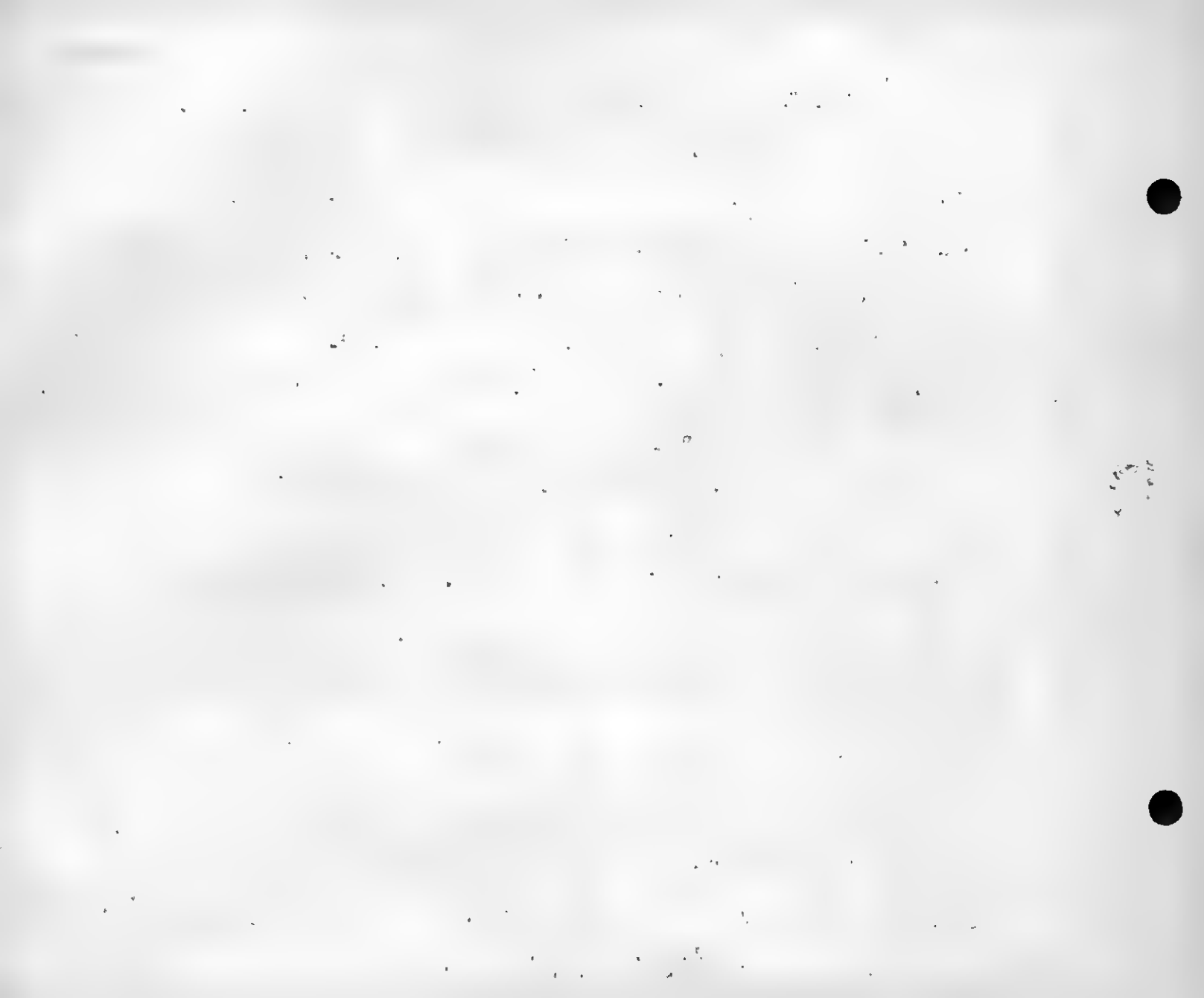
10945

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13956

1. DECEASED-NAME (Type or print) <b>WILLIAM RICHARD BUEHAUS</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>18</b> Year <b>68</b>			2b. HOUR <b>1:45 PM</b>				
3. SEX <b>male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9/1/14</b>		6. AGE (In years last birthday) <b>54</b> YRS.		7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE,</b> Md				
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VEP. ARM. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BREWERY</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1002 FOXCHASE LANE</b>	
14. FATHER'S NAME First <b>FREDERICK</b> Middle <b>BUEHAUS</b> Last <b>PEARL</b>			15. MOTHER'S MAIDEN NAME First <b>PEARL</b> Middle <b>MYERS</b> Last <b>MYERS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW 11</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b> <b>412X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>LEFT BRONCHOPNEUMONIA, UNKNOWN ORGANISM</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PULMONARY EMPHYSEMA AND FIBROSIS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HEALED MILITARY TUBERCULOSIS. POST OPERATIVE RIGHT LOWER LOBECTOMY</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <b>41</b> (this hospital) attended the deceased from <b>10/16/68</b> , 19 <b>68</b> , to <b>10/18/68</b> , 19 <b>68</b> , that <b>(X)</b> (we) lost saw the deceased alive on <b>10/18/68</b> , 19 <b>68</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Neilson Neilson, M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/18/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>NEILSON NEILSON, M. D.</b>						22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>				
23a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>			23b. DATE <b>10/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>ZANNINO FUNERAL HOME</b>			ADDRESS <b>257 S. Coaling St. Baltimore, Md.</b>			25a. DATE BY REGISTRAR <b>10/21/68</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13946

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13957

1. DECEASED-NAME (Type or print)		First <b>Herbert</b>	Middle <b>H</b>	Last <b>BURGESS</b>	2a. DATE OF DEATH Month <b>10</b> Day <b>31</b> Year <b>1968</b>		2b. HOUR <b>11:55 A.M.</b>
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>10/25/1901</b>		6 AGE (In years last birthday) <b>67 YRS.</b>	IF UNDER YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ENGINEER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>8401 Avery Rd.</b>		14. FATHER'S NAME First Middle Last <b>HARRY BURGESS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET TAYLOR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NA</b>		16b. SOCIAL SECURITY NO. <b>217-03-7508</b>		17 INFORMANT Address <b>CATHERINE BURGESS 8401 AVERY</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale secondary to</b> <b>17X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>diffuse chronic pulmonary fibrosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from <b>10/30/</b> , 19 <b>68</b> , to <b>10/31/</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/31/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>Lilia C. Baldonado</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/31/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Lilia C. Baldonado, M.D.</b>		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHOLICAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>J. G. CONNELLY SONS</b>		ADDRESS <b>300 WACE</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





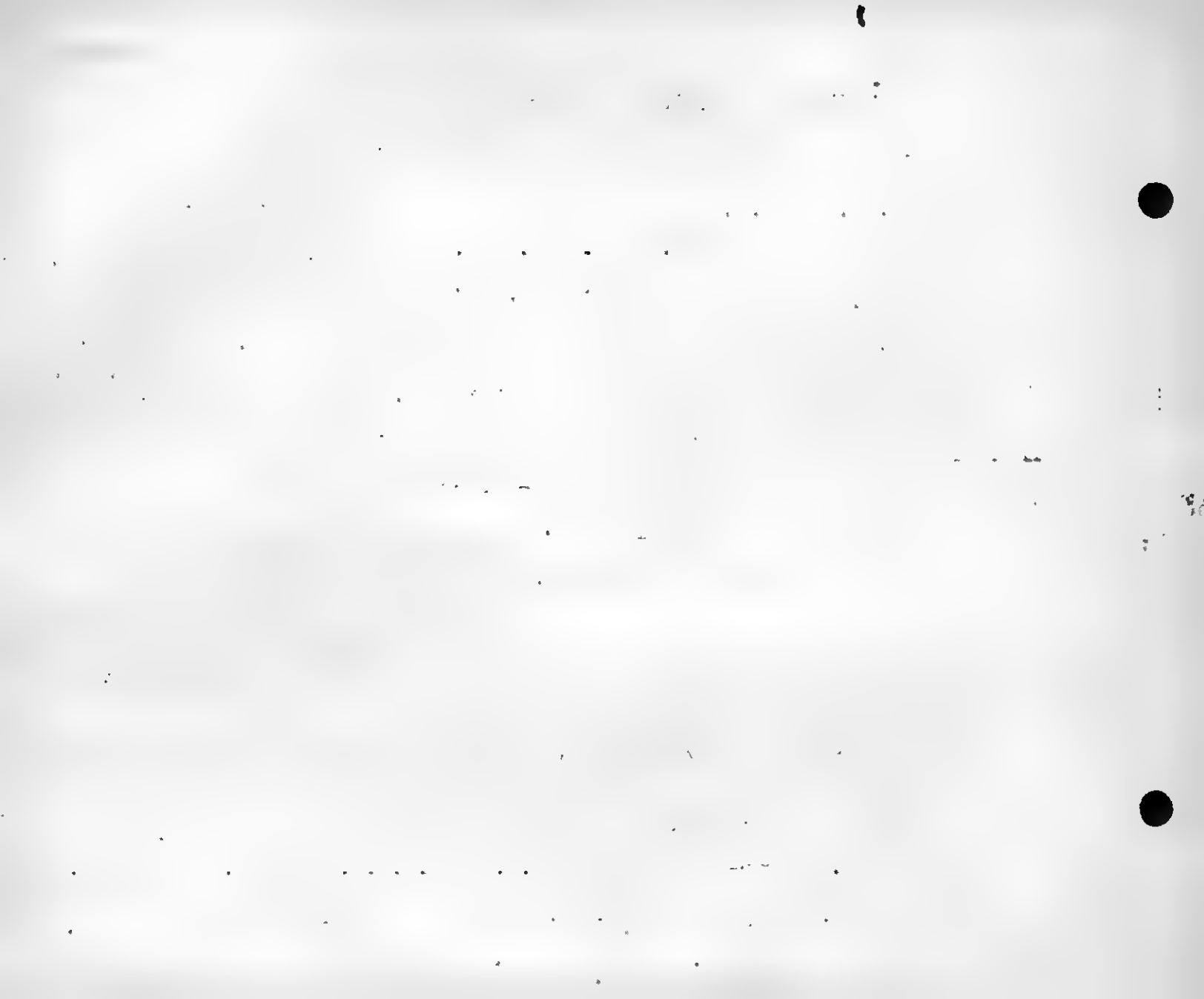
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

13947

13958

1. DECEASED-NAME (Type or print) <b>Virginia Morrow Burnham</b>			2a. DATE OF DEATH <b>10</b> Month <b>6</b> Day <b>68</b> Year			2b. HOUR <b>5:40</b> a.m.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2/28/1898</b>		6. AGE (In years lost birthday) <b>70</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Great Balt. Med. Cen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Towson</b>		13c. CITY OR TOWN <b>Balto. 2121</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME <b>Charles A. Morrow</b>		15. MOTHER'S MAIDEN NAME <b>Maude E. Bellis</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
		16b. SOCIAL SECURITY NO. <b>213-28-2077</b>		17. INFORMANT <b>George H. Burnham, 1018 Rolandvue Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Con Pulmonale*- Severe</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Emphysema</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>12 yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Coronary insufficiency</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>10/4</b> , 1968, to <b>10/6</b> , 1968, that <del>he</del> (we) lost saw the deceased alive on <b>10/4</b> , 1968, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>he</del> (we) <del>did</del> (did not) view the body after death.							
22b. SIGNATURE <b>Dr. S. G. Maghami</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/6/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Shirin-Ghaem Maghami M.D.</b>				22e. ADDRESS <b>G.B.M.C. 6701 N. Charles St.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/8/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Ann's</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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20M 1/65

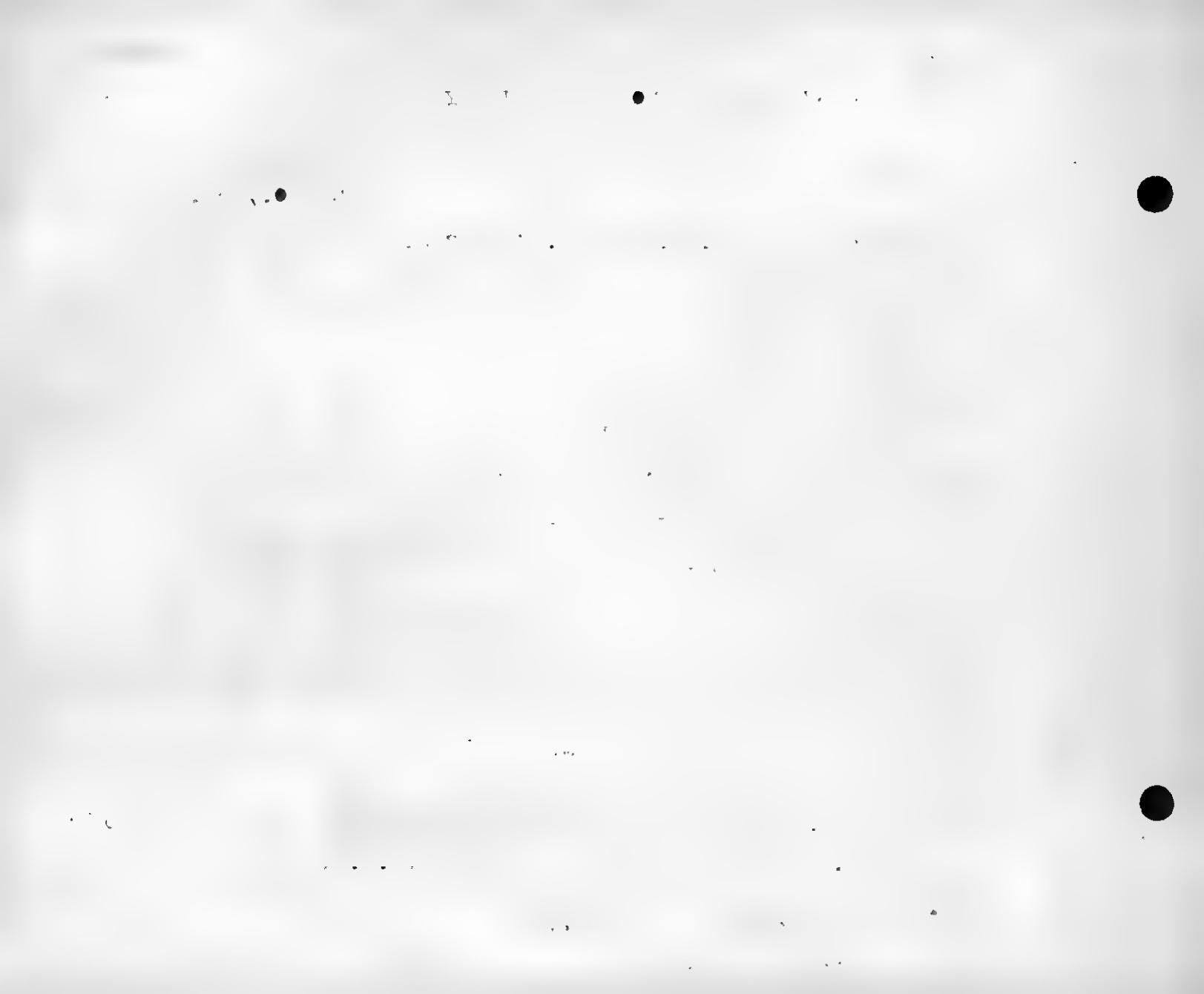
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12048					13959				
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>44 Croftley Road</i>					d. STREET ADDRESS <i>44 Croftley Road</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Namie</i> Middle <i>Florence</i> Last <i>Burns</i>			4. DATE OF DEATH Month <i>October</i> Day <i>14</i> Year <i>1968</i>						
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 25, 1879</i>		9. AGE (In years last birthday) <i>89</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John R. Sparks</i>					14. MOTHER'S MAIDEN NAME <i>Mary Ann Grey</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>None</i>		17. INFORMANT <i>Family records</i>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTIONS (MULTIPLE)</i> 41 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>CORONARY HEART DISEASE</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>42</i>								INTERVAL BETWEEN ONSET AND DEATH <i>1 MINUTE</i> <i>YEARS</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>8/14</i> , 1960, to <i>10/14</i> , 1968, that (I) <del>(we)</del> last saw the deceased alive on <i>10/11</i> , 1968, and that death occurred at <i>4:52 A.M.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Donald L. Somerville</i>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>10/15/68</i>		
22c. PHYSICIAN'S NAME (Type) <i>Donald L. Somerville</i>					22d. ADDRESS <i>TOWSON, MD 21204</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Oct. 16, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Towson, Maryland</i>		
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>					25. DATE BY REGISTRAR <i>OCT 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH										13960	
1. DECEASED NAME (Type or print) <b>Frank</b>			First <b>Joseph</b>		Middle <b>Boy</b>		Last <b>BUSSEY</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>68</b>		2b. HOUR <b>12:28</b> am
3. SEX <b>M.</b>		4. RACE <b>White</b>			5. DATE OF BIRTH <b>10/29/68</b>			6. AGE (in years last birthday) <b>YRS.</b>		IF UNDER 1 YEAR MONTHS <b>6</b>	IF UNDER 24 HRS. HOURS <b>6</b>
7a. BIRTHPLACE (State or foreign country) <b>Towson</b>		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO., MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>GREATER BALTO., MED. CEN.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Jessup</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Holiday Estates Lot A 30</b>	
14. FATHER'S NAME First <b>Francis</b> Middle <b>Milton</b> Last <b>Bussey</b>			15. MOTHER'S MAIDEN NAME First <b>Garnette</b> Middle <b>Sue</b> Last <b>Jenkins</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF <b>RESPIRATORY DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYALINE MEMBRANE DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>PREMATURITY</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>10/29</b> , 19 <b>68</b> , to <b>10/30</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>10/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>A. Finkel</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/30/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>A. FINKEL</b>		22e. ADDRESS <b>G.B.M.C.</b>									
23a. BURIAL, CREMATION, <del>REMOVING</del> (Specify)		23b. DATE <b>10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GBMC</b>		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <b>R. H. H. H. H.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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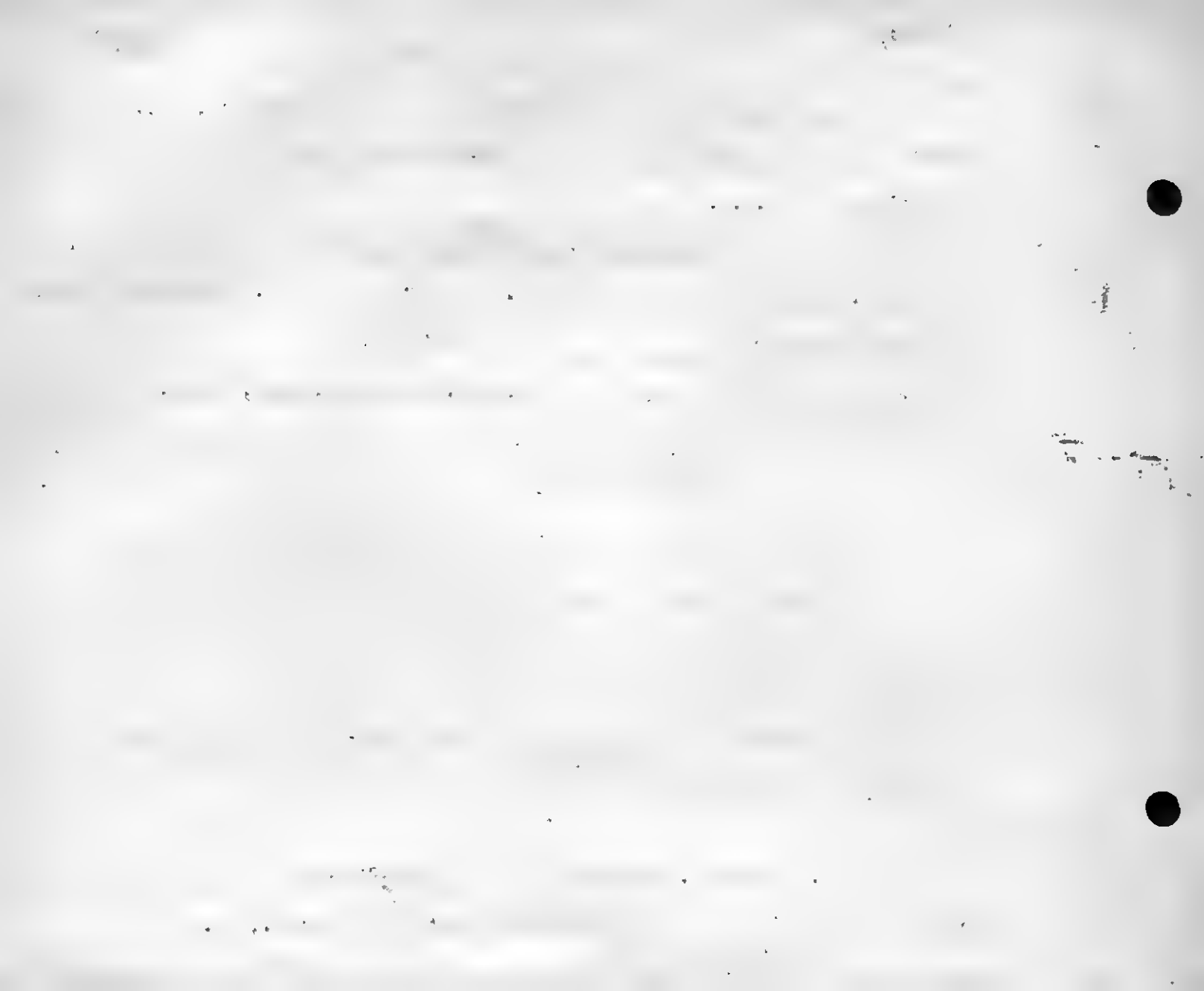
13950

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13961

1. DECEASED-NAME (Type or print) First Middle Last <b>Mary (Marie) Butcher</b>			2a. DATE OF DEATH Month Day Year <b>October 7, 1968</b>			2b. HOUR <b>9pm</b>														
3 SEX <b>female</b>			RACE <b>white</b>			5. DATE OF BIRTH <b>September 28, 1896</b>			6. AGE (In years last birthday) <b>72</b> YRS			7. UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>											
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesapeake Manor Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>13b</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY (Y.N. 157) <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			13e. STREET AND NUMBER <b>430 N. Rose Street 21224</b>								
14. FATHER'S NAME First Middle Last <b>James Machovec</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Marie ?</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>no</b>									16b. SOCIAL SECURITY NO. <b>none</b>			17 INFORMANT <b>Agnes M. Posluszny, dght., above.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Carcinoma of Retroperitoneal Lymph Glands</b> DUE TO, OR AS A CONSEQUENCE OF <b>Lymph Glands</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Wks.</b> <b>6 Months</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <b>9/23, 1968</b> , to <b>10/7, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>Charles F. O'Donnell</b>			DEGREE <b>Dr. Charles F. O'Donnell</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/7/68</b>											
22d. PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>			22e. ADDRESS <b>7501 York Road</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10/9/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>											
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b> <b>3331 Brehms Lane 21213</b>			25a. REC'D BY REGISTRAR <b>OCT 9 1968</b>			25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>														





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23c Film 406-770-168  
**13958**  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**  
**13962**

1. DECEASED NAME (Type or print) <i>William J. Butler</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>29</i> Year <i>1968</i>			2b. HOUR <i>4:30</i> M	
3 SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>12-12-1902</i>		6. AGE (in years last birthday) <i>65</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>12</i> Md.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Summit Nursing Home Records</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute massive myocardial infarct</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Pulmonary fibrosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , to <i>Oct 29, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stanley Ankudas, M.D.</i>				22c. DATE SIGNED <i>10/30/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stanley Ankudas, I.D.</i>				22e. ADDRESS <i>1101 Maiden Choice Lane</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11-1-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harvey Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore</i>	
24. FUNERAL DIRECTOR <i>Wm. S. Miller Inc-745 Balto W. Baltimore</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 31 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13952

CERTIFICATE OF DEATH

13963

1. DECEASED NAME (Type or print) <b>William</b>		First <b>William</b>		Middle <b>CALVERT</b>		Last <b>CALVERT</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>9:20</b> A.		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 27, 1921</b>			6. AGE (In years lost birthday) <b>47</b> YRS.			IF UNDER YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore,</b>			Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>City of Balto</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY (LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>14 1/2 Elmont Ave.</b>					
14. FATHER'S NAME <b>John Earl Calvert</b>		First <b>John</b>		Middle <b>Earl</b>		Last <b>Calvert</b>		15. MOTHER'S MAIDEN NAME <b>Hattie Nicholas</b>		First <b>Hattie</b>		Middle <b>Nicholas</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		(If yes give year or dates of service) <b>W.W.11</b>		16b. SOCIAL SECURITY NO. <b>247-18-3262</b>		17. INFORMANT <b>Mrs Lillian Calvert</b>		Address <b>14 1/2 Elmont Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> <b>5:10</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Secondary to Portal Cirrhosis and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Massive Gastro-Intestinal Bleeding.</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION <b>10/9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bleeding peptic ulcer</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/9/</b> , 19 <b>68</b> , to <b>10/16/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10/16/</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Christiana Feliciano</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/16/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Christiana Feliciano, M.D.</b>		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-19-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>							
24. FUNERAL DIRECTOR <b>Massahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

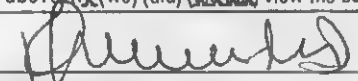

VR A15  
30M REV 11-68

13953

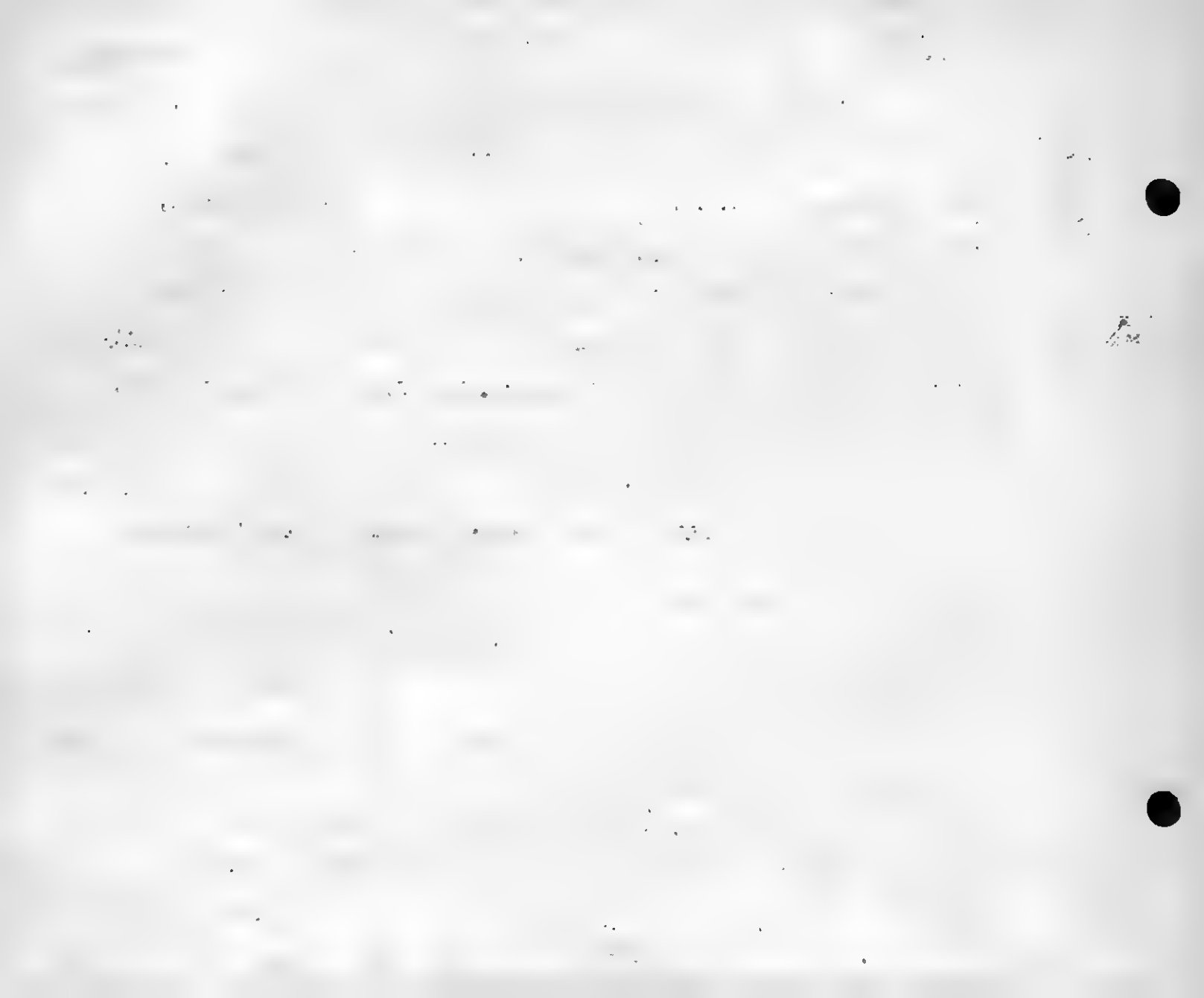
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 6 Film 6406

CERTIFICATE OF DEATH

13964

1. DECEASED-NAME (Type or print)		First <b>OLLIE</b>	Middle <b>MARION</b>	Lost <b>CARPENTER</b>	20. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>68</b>		2b. HOUR <b>1:00A M</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11/18/93</b>		6. AGE (In years lost birthday) <b>75 74 YRS.</b>	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>EASTON, MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>WATERMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>TALBOT COUNTY</b>		13c. CITY OR TOWN <b>EASTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET AND NUMBER <b>Rt 3, Box 29</b>	
14. FATHER'S NAME First <b>CHARLES</b> Middle <b>W.</b> Lost <b>CARPENTER</b>		15. MOTHER'S MAIDEN NAME First <b>LUCY</b> Middle <b>FLEETWOOD</b> Lost		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> 16b. SOCIAL SECURITY NO <b>218 01 69 22</b>			
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, TERMINAL</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC RENAL FAILURE SECONDARY TO MULTIPLE MYELOMA</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO AUTOPSY</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/16/68</b> , 19__, to <b>10/17/68</b> , 19__, that (I) (we) last saw the deceased alive on <b>10/17/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		22c. DATE SIGNED <b>10/17/68</b>		22d. PHYSICIAN'S NAME (Type) <b>RODOLFO G. MIRO, M. D.</b>			
22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		22f. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>EASTON, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Heverin</b>		25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

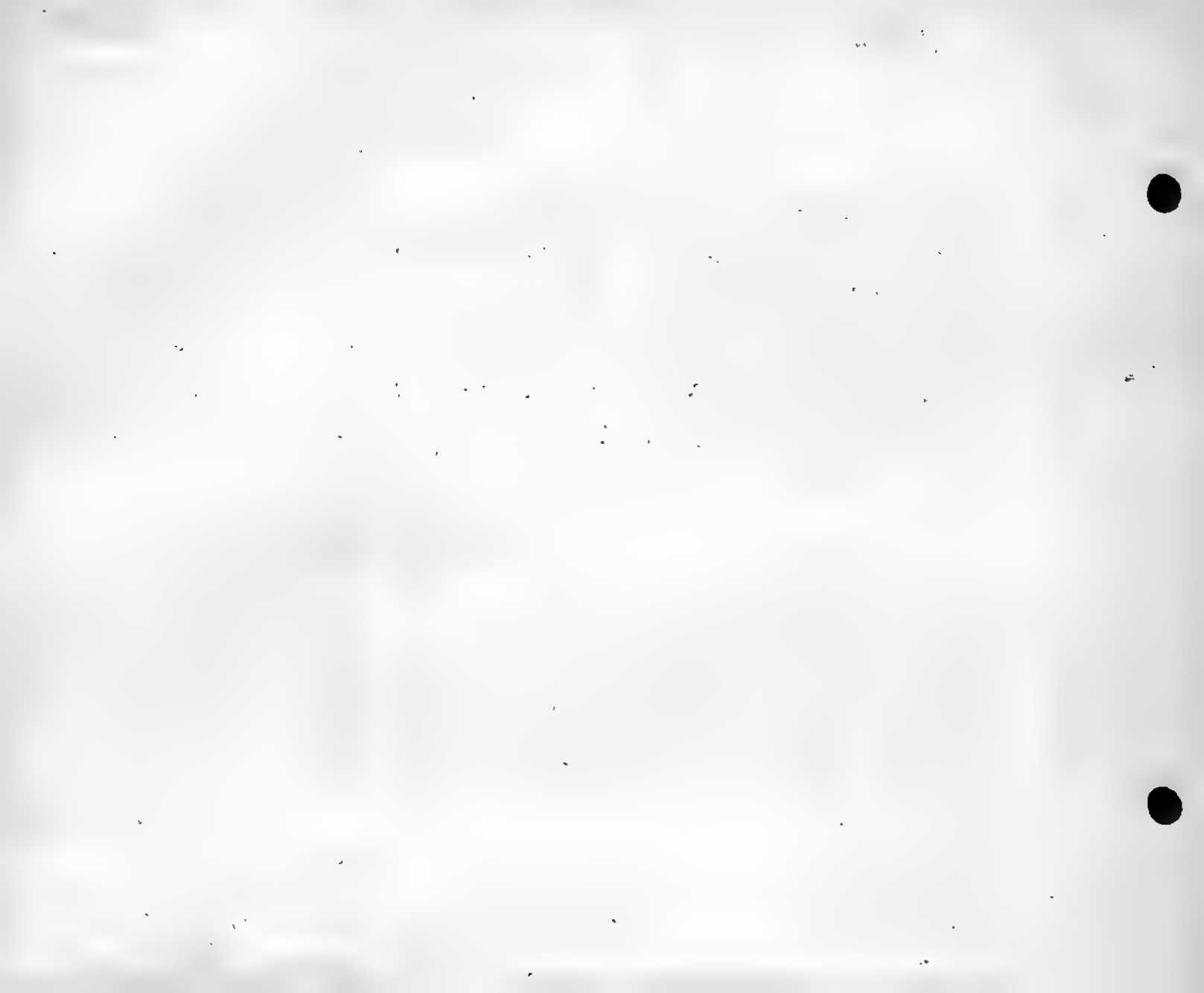
13956

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13965

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b. HOUR		
John			T		CARROLL	OCT 12 1968			11 45 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
M		CAU		JUNE 12, 1875		93 YRS					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
CANANDAIGUA, N.Y.		USA				BALTO.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
TOWSON		DULAND TOWSON N. H.		BYORR.		RAILROAD					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md		=		BALTO.				CAMBRIDGE ARMS APTS. CHARLES ST.			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
JAMES					CARROLL	ELLEN O'BRIEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT					
No			220-44-9394			John G. Carroll Rd 21 OXFORD, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> 4 yrs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brachio-pneumonia</u> 1 week DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4 yrs											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> D.R. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-10</u> , 19 <u>68</u> , to <u>10-12</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>10-11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)					
Philip D. Flynn		10-14-68				Philip D. Flynn M.D.					
22e. ADDRESS		22f. ADDRESS				22g. ADDRESS					
11 E. Chase St.		11 E. Chase St.				11 E. Chase St.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		10/15/68		New Cathedral		Balto.		Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Wm. Cook-Brooks Towson, 1050 York Rd Towson, Md.		OCT 15 1968				Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13955

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

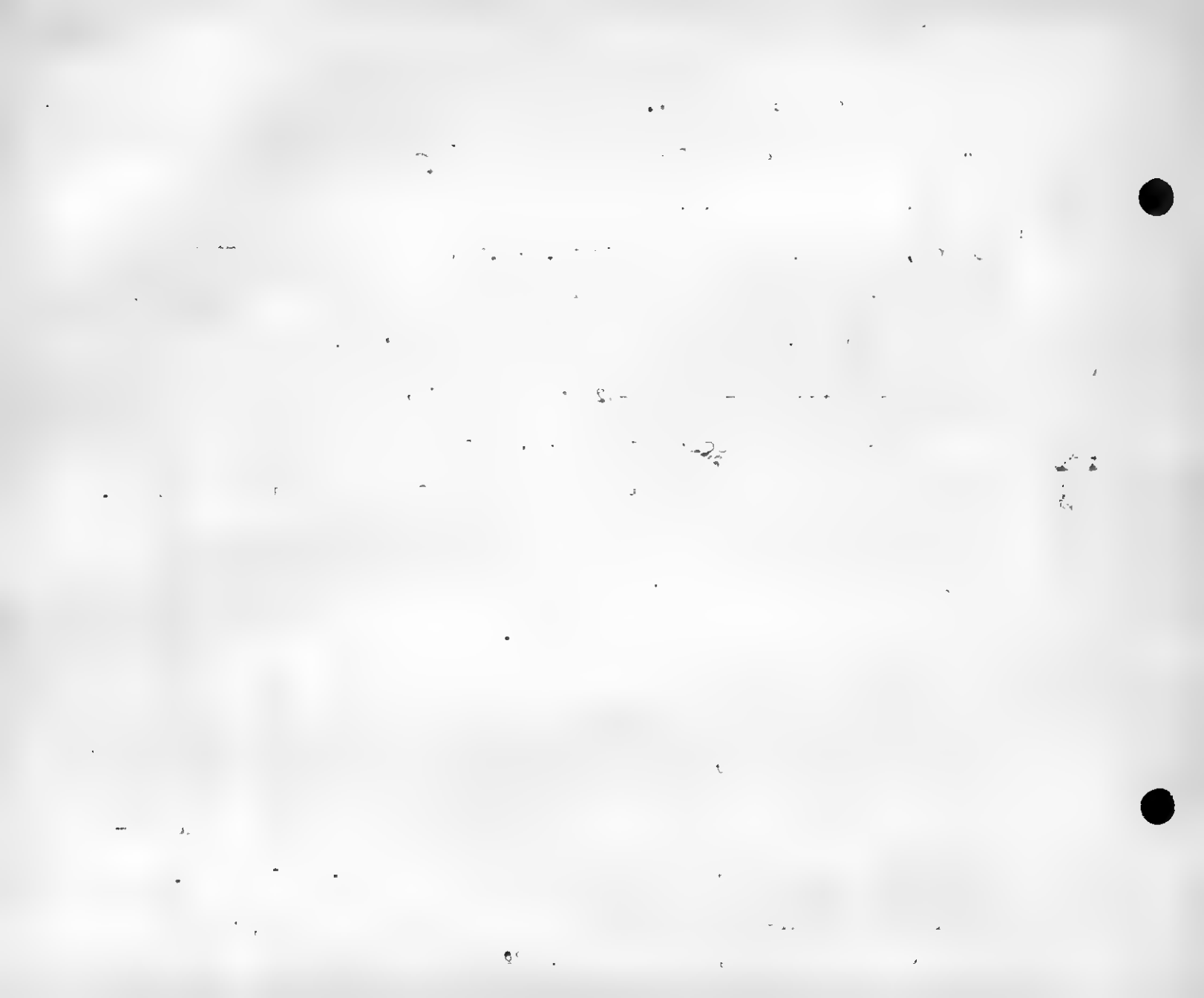
13966

Item#13d

Film#1306

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Florence M. Cecil</b>			2a. DATE OF DEATH 10 Month 10 Day 68 Year			2b. HOUR 1:45am	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>10-19-89</b>		6. AGE (In years lost birthday) <b>78</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>Towson, Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Cent.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>615 Chestnut Ave.</b>							
14. FATHER'S NAME First Middle Last <b>John M. Cecil</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary M. Crassley</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>217-05-4297A</b>		17. INFORMANT Address <b>Pickersgill, Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>4221</b> (b) <b>Arterial sclerosis cardio vascular disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic necrotic cystitis</b>							
19a. DATE OF OPERATION <b>10-9-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pelvic mass r/o malign.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-11</b> , 19 <b>68</b> to <b>10-10</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-10</b> 1968, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE <b>Chassem Pour Adib</b>				22c. DATE SIGNED <b>10-10-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Chassem Pour Adib</b>	
22e. ADDRESS <b>GBMC 6701 N. Charles St.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-12-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, 1050 York Rd. 22204</b>				25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Filing 107 12/3/68 <b>13953</b> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>										<b>13967</b>	
1. DECEASED-NAME (Type or Print) <b>LEWIS</b>				First Middle Last <b>J. CHEEK</b>				2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> 10/31/68 19 6:00AM			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>12/3/13</b>		6 AGE (In years last birthday) <b>54</b> YRS		7c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>31</b> Year <b>1968</b> 10:00A			
7a BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md.					
10 CITY OR TOWN OF DEATH <b>FT. HOWARD</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CARPENTER'S HELPER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>MARYLAND</b>				13b COUNTY <b>HARFORD</b>		13c CITY OR TOWN <b>STREET</b>		13d NO DE CITY, MIST? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME First Middle Last <b>JOSEPH CHEEK</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>MYRTLE JENNINGS</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16b SOCIAL SECURITY NO <b>WW II 212 14 05 69</b>		17 INFORMANT ADDRESS <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE WITH COR PULMONALE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>443X</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CHRONIC ALCOHOLISM. PULMONARY EMPHYSEMA</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>None</b> HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, town, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>M B Davis</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>10/31/68</b>			
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M. D., 6800 MORN INGTON RD., BALTIMORE, MD. 21222</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>11/2/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air, Harford Co., Md.</b>			
24 FUNERAL DIRECTOR <b>JOHN H. HARKINS</b>				ADDRESS <b>Harkins Funeral Home Delta, Pennsylvania</b>				25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13968
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
VINCENT		L.	CLISHAM	October 18, 1968.			5:30 A			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.	
Male	White		October 18, 1895.		73 YRS.					
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland	USA				Baltimore, Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Parkville		2529 Hillcrest Rd.			Retired-- Insurance					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INS. DE. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		Baltimore		Baltimore				2529 Hillcrest Road Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William Clisham			Mary Ellen Ford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No			214-03-4754A		Mrs. Adelaide Clisham		(Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>10 yrs.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>January, 1968</u> to <u>October 18, 1968</u> , that (I) (we) lost the deceased alive on <u>October 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>A. Allan Spier</u> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/18/68</u>			
22d. PHYSICIAN'S NAME (Type) A. Allan Spier M.D.					22e. ADDRESS 1501 Pentridge Rd.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10/21/68.		Lorraine Park Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214					25a. REC'D BY REGISTRAR DATE Oct 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

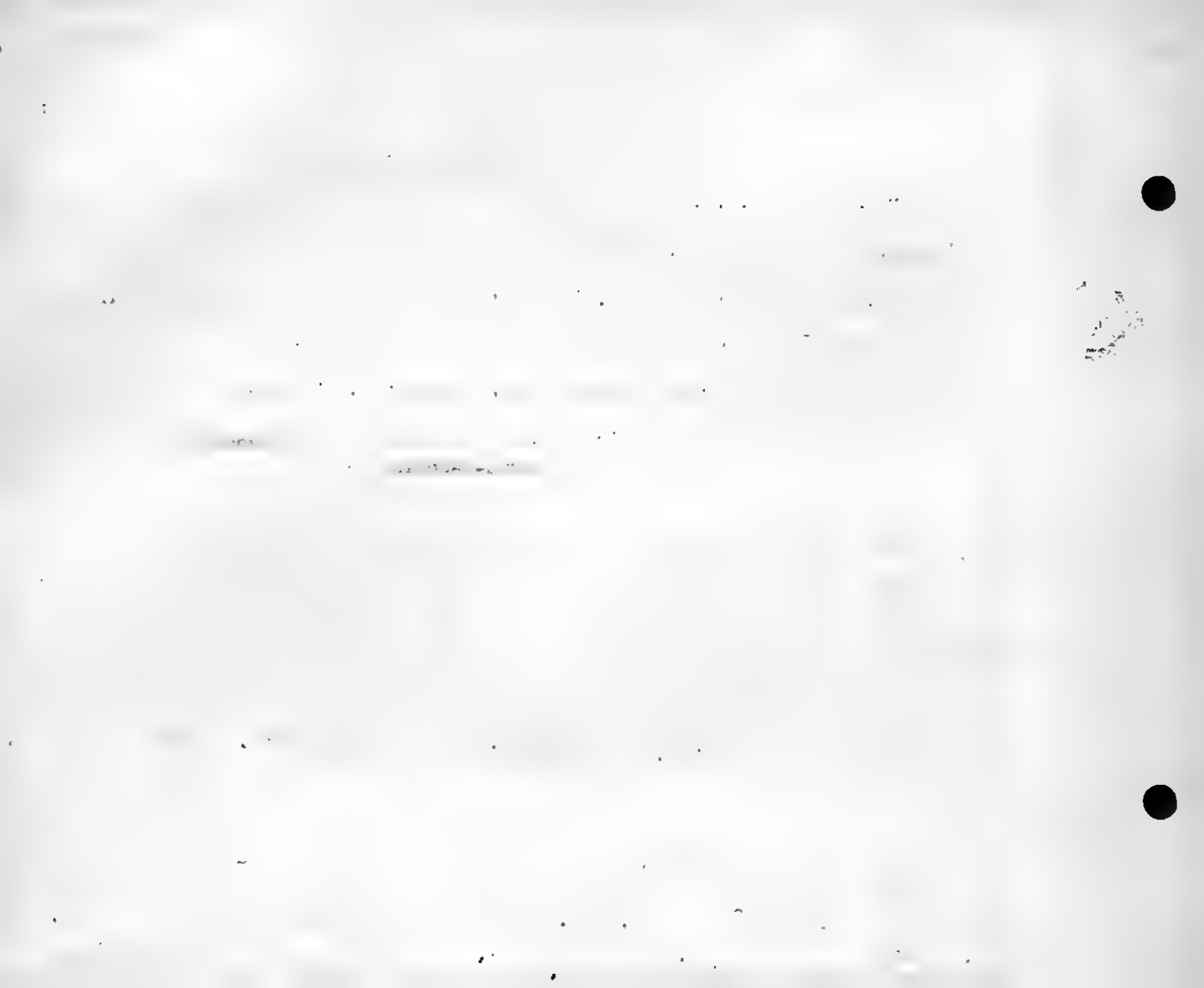
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13955

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

13969

1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR PM	
HENRY STIRLING COCHRAN					October 3, 1968		10:40	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (in years lost birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	WHITE		January 28, 1921		47 YRS			
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.	
Maryland	U.S.A.				Baltimore			
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson	ST. JOSEPH HOSPITAL		Manager		Duplicating			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Maryland	Baltimore Co.		Balto. 34		2463 Woodcroft Rd. 21234			
14 FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost
Harry W. Cochran				Beatrice				Murphy
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address		
Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) WWII		216-12-5637		Mrs. Eleanor K. Cochran		(Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage secondary to hypertensive</u> DUE TO, OR AS A CONSEQUENCE OF <u>cardio-vascular disease</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 3</u> , 19 <u>68</u> , to <u>Oct. 3</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Oct. 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE <u>Christina Feliciano, M.D.</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/4/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Christina Feliciano, M.D.		7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial	10/7/68	St. John's		Longgreen				Md.
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.		DATE OCT 8 1968		J. Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13954										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13970							
CERTIFICATE OF DEATH																											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				Month		Day		Year		2b. HOUR									
Coffin, Roscoe		Coffin								10		13		68		1		PM									
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)				IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		IF UNDER 24 HRS. HOURS		IF UNDER 24 HRS. MIN.									
M		W		9/15/72				96																			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH																					
PENNA.		U.S.A.				BALTIMORE						Md.															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY															
Catonville				Summit				Optometrist																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER																			
Md		BALTO		BALTO				1420 Bolton																			
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last									
George				Steeple		Coffin		Susan				May		Kamus													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17. INFORMANT				Address															
Yes				220-20-1534				Mrs William W. Campbell				241 Hunt Club Rd.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																											
PART 1. DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE																											
DUE TO, OR AS A CONSEQUENCE OF																											
(b) CONGESTIVE HEART FAILURE																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c) PNEUMONIA																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
								YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If neither, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION				Street or R.F.D. No				City or Town				County				State			
22a. I certify that (I) (the hospital) attended the deceased from 9/19, 1968, to 10/13, 1968, that (I) (we) last saw the deceased alive on 10/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE																											
S. Lee M.D.																											
22c. DATE SIGNED																											
10/13/68																											
22d. PHYSICIAN'S NAME (Type)																											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)				(County)				(State)							
Burial				Oct. 16, 1968				Crestlawn Cemetery				Ellicott City				Howard Co., Md.											
24. FUNERAL DIRECTOR																											
Harry H. Witzke																											
321 Columbia Pike																											
Ellicott City, Md. 21043																											
25a. REC'D BY REGISTRAR																											
OCT 16 1968																											
25b. REGISTRAR'S SIGNATURE																											
J. Charles Judge																											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13960

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13971

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last <b>JAMES DEWEY COLE</b>			2a. DATE OF DEATH Month Day Year <b>OCTOBER 4, 1968</b>		2b. HOUR M
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>May 23, 1898</b>		6. AGE (In years last birthday) <b>70</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Rodgers Forge</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>408 Dunkirk Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Rail-ROAD</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. CITY OR TOWN <b>Baltimore</b>	13c. CITY OR TOWN <b>Rodgers Forge</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>408 Dunkirk Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Charles M. Cole</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma W. Weinrich</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Lillian G. Cole S. me</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>1-5x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrum</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of Prostate</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>1 year</b> <b>10 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>177x</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1 July, 1946</b> to <b>4 Oct, 1968</b> , that (I) (we) last saw the deceased alive on <b>4 Oct 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles A. Reier M.D.</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7 Oct 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Charles A. Reier</b>		22e. ADDRESS <b>6701 York Rd. Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-7-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR ADDRESS <b>6500 York Rd. Baltimore, Md.</b>					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13962

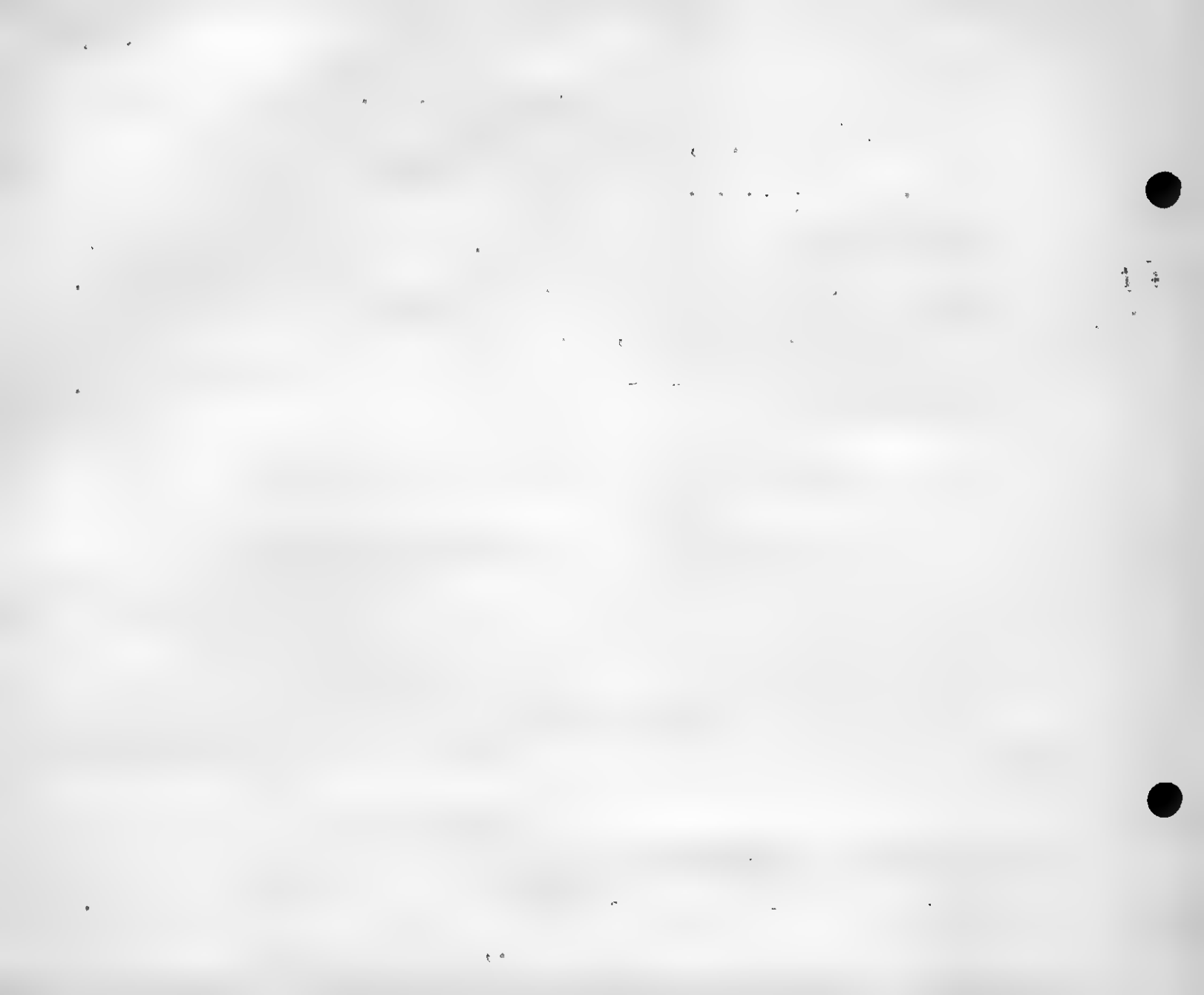
13972

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	Month	Day	Year	2b HOUR
Raymond Edward Colliflower, Jr.					10	3		1968	8:45 A.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		Year	2d HOUR
Male	White	Sept. 14, 1928	40 YRS			Oct. 3		1968	8:45 A.M.
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.	U.S.A.				Baltimore				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Edmondson Heights		1502 Clairidge Rd.		Civil Engineer		Balto. City			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.		Baltimore		Ed. Hghts		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1502 Clairidge Rd.	
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Raymond E. Colliflower, Sr.					Mary R. Colley				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
		217-24-3997		Mrs. Mary R. Colliflower		1502 Clairidge Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>atherosclerosis CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days -</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <u>Hypertensive cardiac vascular Disease 4 yrs</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		J. Nelson McKay		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		J. Nelson McKay				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Oct. 3, 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		10-7-1968		Lorraine Park		Woodlawn			Md.
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
G. Howard Strong 3207 W. North Ave.,						DATE OCT 7 1968		Charles Judge	

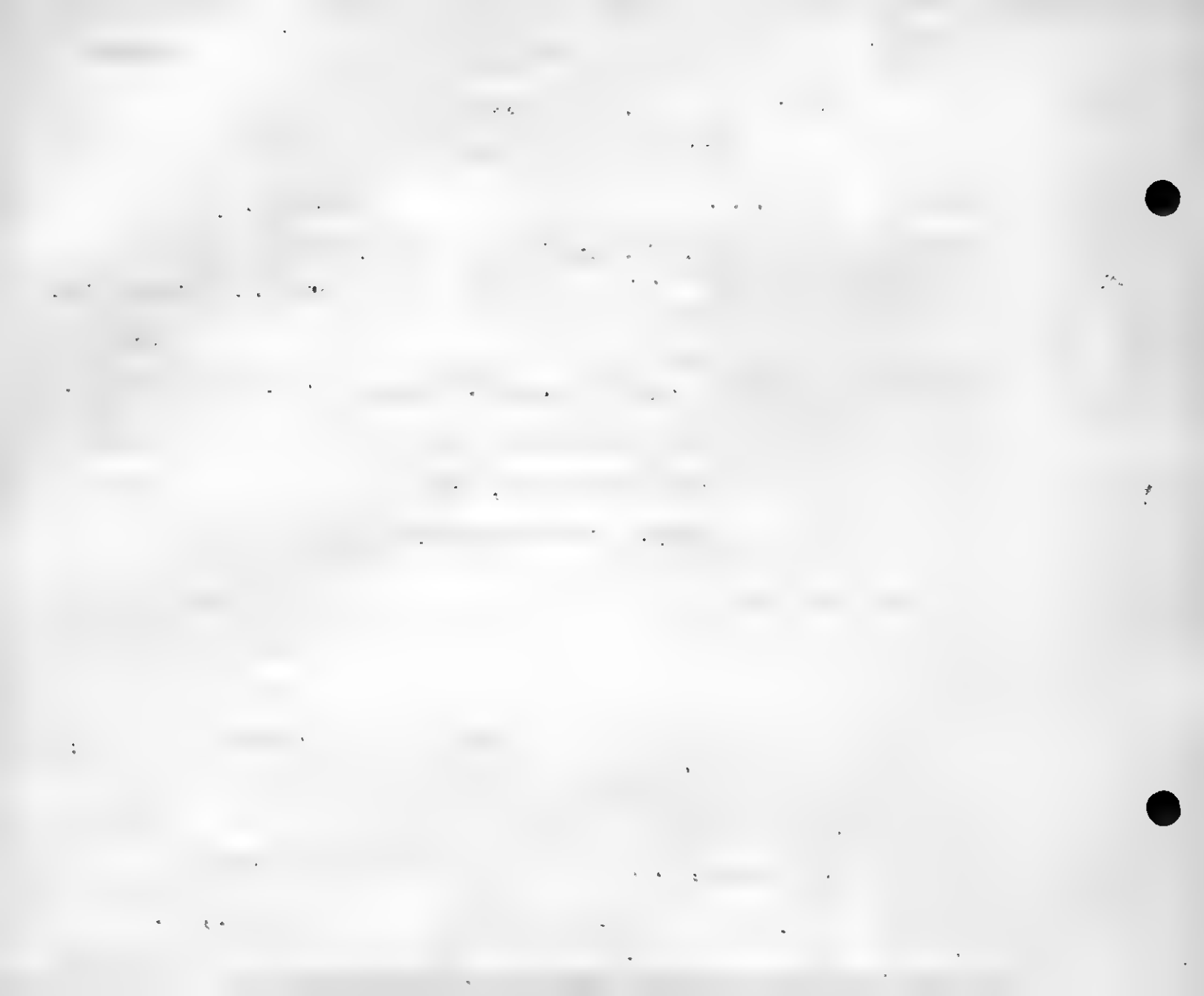


1  
4  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13962					13973					
1 DECEASED NAME (Type or print)					First Middle Last		2a. DATE OF DEATH		2b. HOUR	
JAMES W. CONWAY							Month 10 Day 15 Year 68		6:15 PM	
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		NEGRO		11/25/96		71 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				BALTIMORE, Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VET. ADM. HOSPITAL			PAPER HANGER				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND					BALTIMORE				932 W. LEXINGTON STREET	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
						LULA FLETCHER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
YES			WW 11		217 14 91 42 CLIN.RECORDS, VA HOSP. FORT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, UNKNOWN ETIOLOGY									DAYS	
1621 DUE TO, OR AS A CONSEQUENCE OF METASTASES TO BRAIN, BONES									UNKNOWN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF SQUAMOUS CELL CARCINOMA LEFT LUNG										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 8/28/68, 19__, to 10/15/68, 19__, that (I) (we) last saw the deceased alive on 10/15/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
NEILSON NEILSON, M.D.									10/16/68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL		10-21-68		BALTIMORE NATIONAL			BALTIMORE, MD.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Chung O. Wilson					WILSON FUNERAL HOME		OCT 21 1968		Charles Judge	
					1000 Brantley Ave. Baltimore, Md.					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13963										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13974																																							
CERTIFICATE OF DEATH																																																											
1 DECEASED NAME (Type or print) <b>Lottie GAY Currens</b>										2a. DATE OF DEATH <b>10</b> Month <b>25</b> Day <b>68</b> Year										2b. HOUR <b>6.30</b> M																																							
3 SEX <b>F</b>										4. RACE <b>W</b>										5 DATE OF BIRTH <b>3.27.1911</b>										6. AGE (In years last birthday) <b>57</b> YRS.										7 UNDER 1 YEAR MONTHS DAYS										8 UNDER 24 HRS. HOURS MIN									
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>										7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH <b>BALTIMORE</b> Md.																													
10. CITY OR TOWN OF DEATH <b>Glen Arm</b>										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Long Green Rd</b>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>																													
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <b>Md</b>										13b. COUNTY <b>BALTO.</b>										13c. CITY OR TOWN <b>Glen Arm</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER <b>Long Green Rd</b>																			
14 FATHER'S NAME First <b>John</b> Middle <b>Smith</b> Last <b>Deusilla</b>										15. MOTHER'S MAIDEN NAME First <b>Deusilla</b> Middle <b>?</b> Last <b>?</b>																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. <b>218463474</b>										17 INFORMANT <b>Robert Chester Currens, Same as 13</b>										Address																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Colon.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 years.</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION <b>Sep. 29. 1967</b>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carlinoma</b>										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1962</b> to <b>10.25.1968</b> , that (I) (we) lost the deceased alive on <b>10.19.1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <b>Kerth A. Manley</b>										22c. DATE SIGNED <b>10.26.68</b>										22d. PHYSICIAN'S NAME (Type) <b>KERTH A. MARILEY</b>										22e. ADDRESS <b>2545, YORK ROAD, TIMONUM MD 21153</b>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE <b>10/28/68</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Church of the Redeemer</b>										23d. LOCATION (City or Town) <b>Long Green, Md</b> (County) <b>Md</b> (State) <b>Md</b>																													
24. FUNERAL DIRECTOR <b>Wm. Corb. Brooks Towson</b>										25a. REC'D BY REGISTRAR <b>OCT 29 1968</b>										25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>																																							

MEDICAL CERTIFICATION



13964

CERTIFICATE OF DEATH

13975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1, 2 and 3 and 4. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>David W. Dallas Jr</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>1968</b>			2b. HOUR <b>2 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 17 1895</b>		6. AGE (in years last birthday) <b>73</b> YRS		7. UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>14</b>	
7a. BIRTHPLACE (State or foreign country) <b>Penn</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>(Parkville) Balto. Md.</b>			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2601 PATT. HILL AVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Security</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2601 PATT. HILL AVE</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>J</b> Last <b>Dallas</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>Boyer</b> Last <b>Boyer</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (known) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>166-28-6691</b>		17. INFORMANT <b>FRANCES E DALLAS</b>		Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse &amp; congestive failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Exfoliated Carcinoma &amp; metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with uremia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b> <b>1 yr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Malnutrition &amp; Debilitation</b>									
19a. DATE OF OPERATION <b>10/16/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exfoliated Carcinoma &amp; metastasis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>10</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Exfoliated Carcinoma &amp; metastasis</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> NOT while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>9005 Hartford Rd</b>		City or Town <b>ROSLYN</b>		County <b>Penn</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 1968</b> to <b>Oct 1968</b> , that (I) (we) last saw the deceased alive on <b>10/13/68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frank T. Kasik Jr</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/15/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>FRANK T. KASIK JR</b>		22e. ADDRESS <b>9005 Hartford Rd</b>							
23a. BURIAL, CREMATION, REMOVAL, DISPOSAL <b>BURIAL</b>		23b. DATE <b>10/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>		23d. LOCATION (City or Town) <b>ROSLYN</b>		County <b>Penn</b>	
24. FUNERAL DIRECTOR <b>CHAS. T. EVANS Jr</b>		ADDRESS <b>8802 Hartford Rd</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)  
30M REV. 1-64

13820										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13832																																																											
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
Baby Boy Karl DANNENFELSER										10 Month 5 Day 68 Year										M																																																											
3 SEX Male										4 RACE Cau										5 DATE OF BIRTH 10/4/68										6 AGE (In years last birthday) YRS.										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS DAYS										IF UNDER 24 HRS HOURS										IF UNDER 24 HRS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md.																																																	
10 CITY OR TOWN OF DEATH Baltimore Towson										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center										12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) NONE										12b. KIND OF BUSINESS OR INDUSTRY NONE																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE Maryland										13b. COUNTY Harford										13c. CITY OR TOWN Forest Hill										13d. INS DE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 234 Bynum Ridge Road																																							
14. FATHER'S NAME First Middle Last Robert James DANNENFELSER										15. MOTHER'S MAIDEN NAME First Middle Last Doris Virginia Marsh										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. NONE										17. INFORMANT (Name) 538-0735 Address 234 Bynum Ridge Rd. (Rt. #2) Mr. Robert J. DANNENFELSER Forest Hill, Maryland 21050																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
IMMEDIATE CAUSE (a) Respiratory failure										DUE TO, OR AS A CONSEQUENCE OF																																																																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7735										(b) Hyaline membrane disease										DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										Prematurity																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from 10/4, 1968, to 10/5, 1968, that (I) (we) last saw the deceased alive on 10/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE [Signature] DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 10/5/68																																																											
22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.										22e. ADDRESS 6701 N. Charles Street																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Oct. 7, 1968										23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cath. Ch. Cem.										23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Maryland 21014																																																	
24. FUNERAL DIRECTOR Joseph William Foster										ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014										25a. REC'D BY REGISTRAR DATE OCT 8 1968										25b. REGISTRAR'S SIGNATURE [Signature]																																																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13965										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13976																													
1. DECEASED NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																			
Brynn Bryn Protheroe										DAVIES										Month 10 Day 28 Year 1968										2 P. M.																			
3 SEX										4. RACE										5. DATE OF BIRTH										6 AGE (In years last birthday)										7. COUNTY OF DEATH									
Male										White										June 10, 1902										66 YRS.										Baltimore, Md.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																			
Whales										USA																				Baltimore,																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																			
Towson										ST. JOSEPH HOSPITAL										Retired Industrial Engineer																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER									
Maryland																				Baltimore										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										40003 Parkwood Ave.									
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																			
Thomas										Davies										Mary										Protheroe																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO										17 INFORMANT										Address																			
No										212-09-8062										Mrs. Elizabeth Ann Davies										(Same)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
										IMMEDIATE CAUSE (a) Bronchogenic carcinoma of the right lung																																							
										DOE TO, OR AS A CONSEQUENCE OF										XXXXXX with extensive metastasis to																													
										(b) liver and left adrenal gland.																																							
										DOE TO, OR AS A CONSEQUENCE OF																																							
										(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (this hospital) attended the deceased from 10/18/1968, to 10/28/1968, that (I) (we) lost saw the deceased alive on 10/28/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										22c. DATE SIGNED																																							
Christina Feliciano, M.D.										10/28/68																																							
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																							
Christina Feliciano, M.D.										7620 York Rd., Towson, Md. 21204																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
Burial										11/1/68										Slateville Cemetery										Delta, Pa.																			
24. FUNERAL DIRECTOR										ADDRESS										25a. RECEIVED BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
Leonard J. Ruck, Inc. Balto. Md. 21211																				OCT 30 1968										[Signature]																			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13966

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13977

1. DECEASED-NAME (Type or print)			First <b>JOHN</b>	Middle <b>LARKIN</b>	Last <b>DAWSON</b>	2a. DATE OF DEATH <b>10</b> Month <b>8</b> Day <b>68</b> Year			2b. HOUR <b>A</b> <b>7:57</b> M		
3. SEX <b>MALE</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>11-26-1912</b>			6. AGE (in years last birthday) <b>55</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GR. BALTO. MED. CENTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Agent- Trucking Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <del>XXXXXX Pa.</del> <b>Loysburg, Pa.</b>			13b. COUNTY <b>Loysburg, Pa.</b>			13c. CITY OR TOWN <b>Loysburg</b>			13d. INS. OR CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>Loysburg, Pennsylvania</b>			14. FATHER'S NAME First <b>James</b> Middle <b>Dawson</b> Last <b>Larkin</b>			15. MOTHER'S MAIDEN NAME First <b>Loretta</b> Middle <b>Larkin</b> Last <b>Larkin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT <b>Virginia Dawson - Loysburg, Pennsylvania</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GROSS METABOLIC DISTURBANCE &amp; WEIGHT LOSS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COMPLETE ESOPHAGEAL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CA ESOPHAGUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>150x</b>											
19a. DATE OF OPERATION <b>9/25</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-18</b> , 19 <b>68</b> , to <b>10-8</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/8</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dost Mohammed</i>			DEGREE <b>DOST MOHAMMED M.D.</b>			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10-8-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DOST MOHAMMED M.D.</b>			22e. ADDRESS <b>6701 N. CHARLES ST. BALT. MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-11-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Elsworth Armacost -4600 Liberty Hghts. Ave.</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

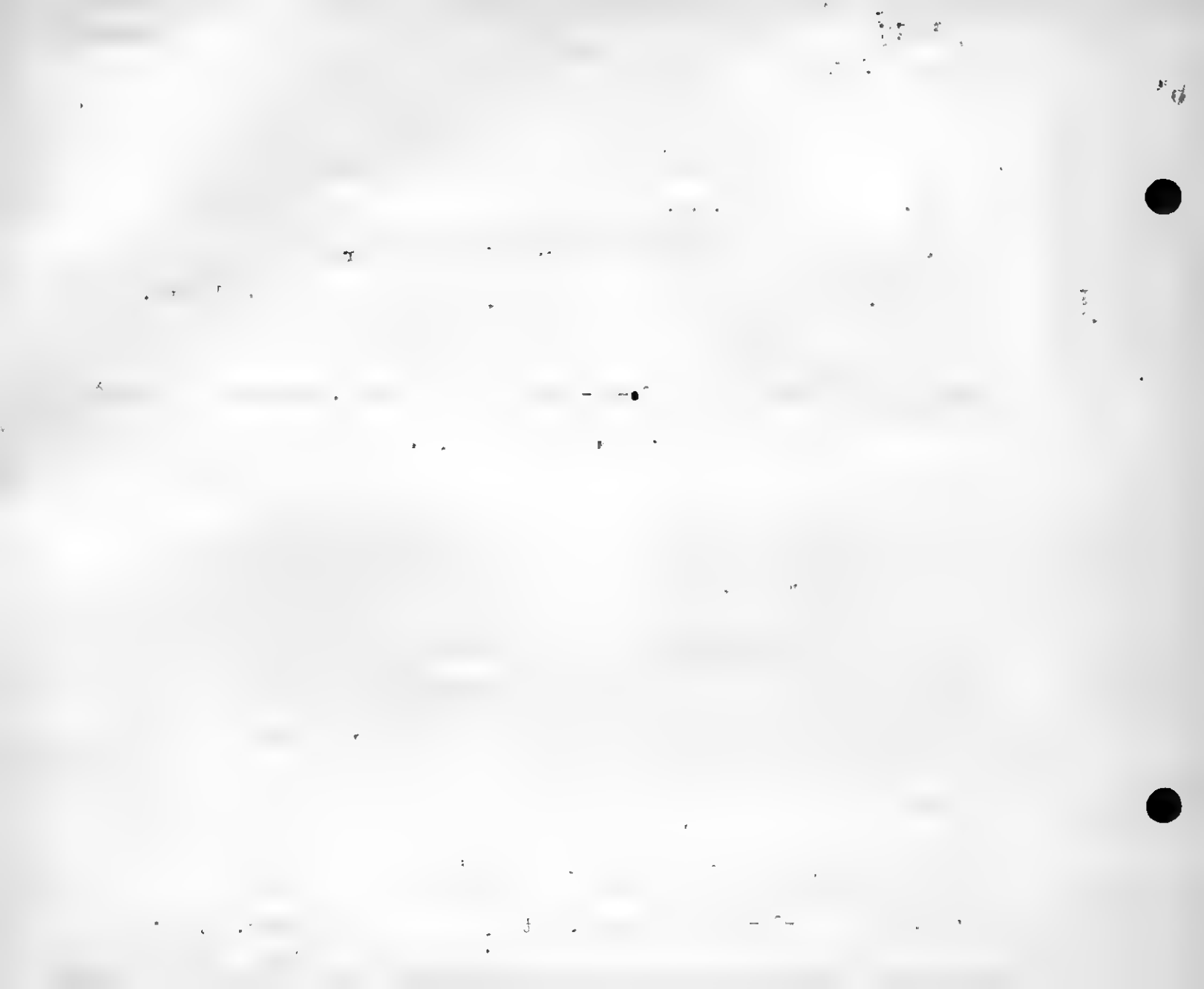
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove of the papers, P. 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13867

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13978

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
William J. Denley						10	Month	28	Day	68	Year	9:46A.
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Caucasian		10/3/27			41		MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Md.		U.S.A.				Baltimore Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore			Greater Balto. Med. Center			Printer						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.					Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3329 Elm Ave.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT							
yes			WW2		Eva M. Denley (named)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Lobar pneumonia, bilateral</u>												
481X DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) _____ DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
49 Fatty metamorphosis of liver												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Yes				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work												
22a. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>68</u> , to <u>10/28</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>10/28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		22c. DATE SIGNED										
Rudiger Breiteneker, M.D.		10/28/68										
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS										
		6701 N. Charles Street										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		10-31-68		Balto. Nat		Balto. Co.		Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Charles J. Denney		NOV 1 1968				Charles Judge						



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

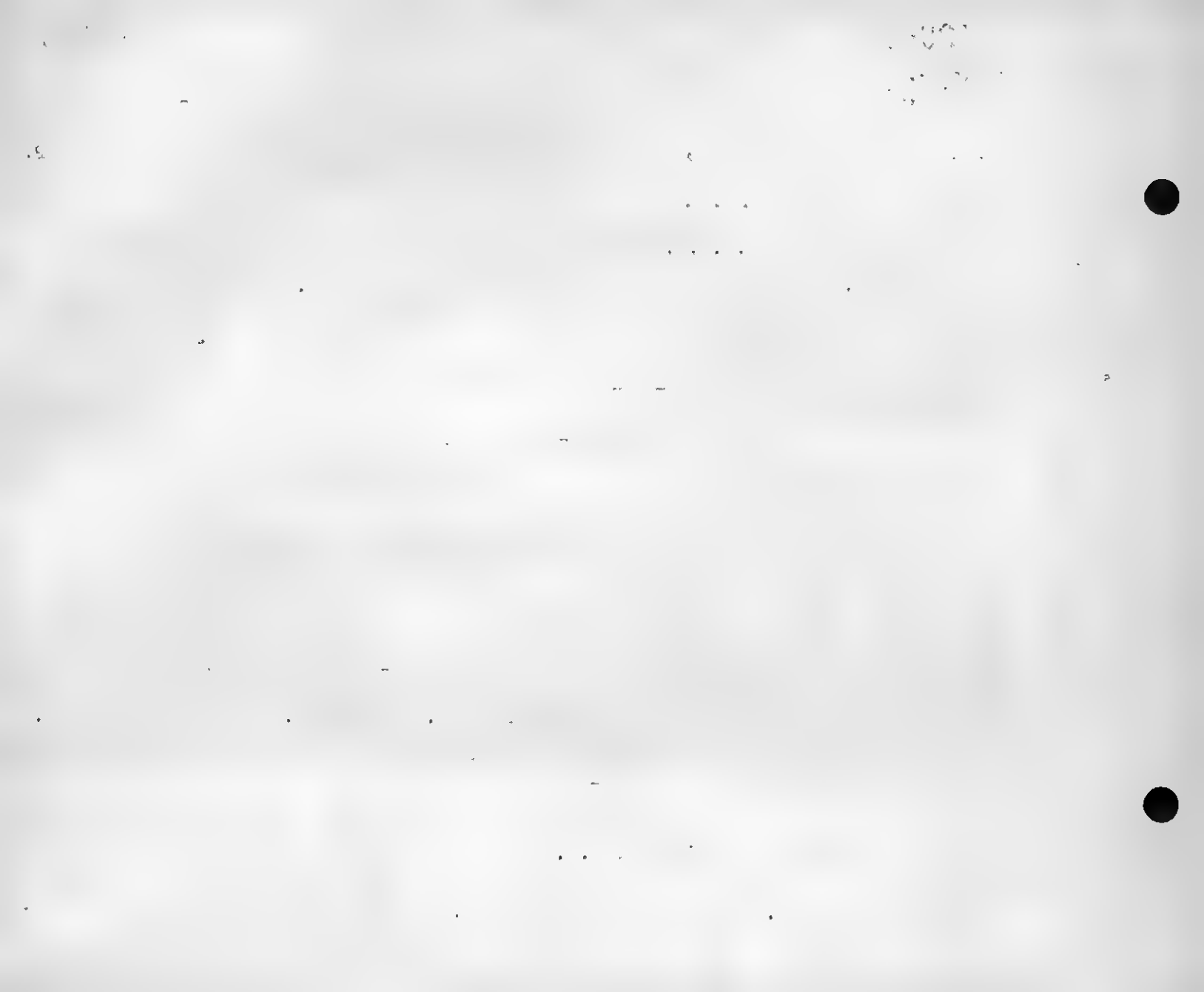
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13968

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13979

1 DECEASED NAME (Type or Print) <b>CHARLES DOMONIC</b>			First Middle Last <b>DISTEFANO</b>			2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI DEATH MATED <input type="checkbox"/> <b>10-23</b> 19 <b>68</b>			2b HOUR <b>10:30</b> A.M.				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>July 29, 1947</b>		6 AGE (In years last birthday) <b>21</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>BALTIMORE</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B.B.M.C. Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carrier</b>				12b KIND OF BUSINESS OR INDUSTRY <b>Horses</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>				13b COUNTY <b>Baltimore</b>				13c CITY OR TOWN <b>Owings Mills</b>				13d INSIDE CITY, IN 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <b>Rt. 1 Box 290</b>				14 FATHER'S NAME First Middle Last <b>Anthony Dominic DiStefano</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Carmella L. Manno</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>213-52-6508</b>				17 INFORMANT <b>Anthony DiStefano</b>				ADDRESS <b>Rt. 1 Box 290 Owings Mills Md</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-cranial injuries</b> <b>315.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>8244</b>													
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>10:00 10-23 19 68</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Drag racing - fell out of auto</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>street</b>				21f LOCATION Street or R.F.D. No City or Town County State <b>Tuften Ave. &amp; Falls Rd. Baltimore Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Charles S. Springate</i>				EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED <b>October 24, 1968</b>	
23a BURIAL, CREMATION, REMOVA. (Specify) <b>Burial</b>				23b DATE <b>Oct. 26, 1968</b>				23c NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gardens Finksburg Carroll Md.</b>				23d LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24 FUNERAL DIRECTOR <i>W. J. Ellhardt</i>				ADDRESS <b>Owings Mills, Md</b>				25a REC'D BY REGISTRAR DATE <b>OCT 28 1968</b>				25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



13969

## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>MINNA ANNA DIVEN</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>11</b> Year <b>68</b> 4 <b>30</b> HOUR <b>A M</b>		
3. SEX <b>FEMALE</b>		4 RACE <b>CAUC</b>		5 DATE OF BIRTH <b>01-18-91</b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>BALTIMORE</b>			12b KIND OF BUSINESS OR INDUSTRY		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GRTR. BALTO. MED. CENTR.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission to STATE) <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Timonium</b>	
13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e STREET AND NUMBER <b>101 Springside Dr.</b>			
14 FATHER'S NAME First Middle Lost <b>Ludwig Faber</b>			15 MOTHER'S MAIDEN NAME First Middle Lost <b>Louisa Raffel</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-32-4148 A</b>		17 INFORMANT Address <b>Miss Betty Lou Faber Same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-08</b> , 19 <b>68</b> , to <b>10-11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-11</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>D.G. Carolis</b>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STATE PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/11/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>D.G. CARALIS</b>		22e. ADDRESS <b>GBMC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-14-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd. Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR <b>OCT 17 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



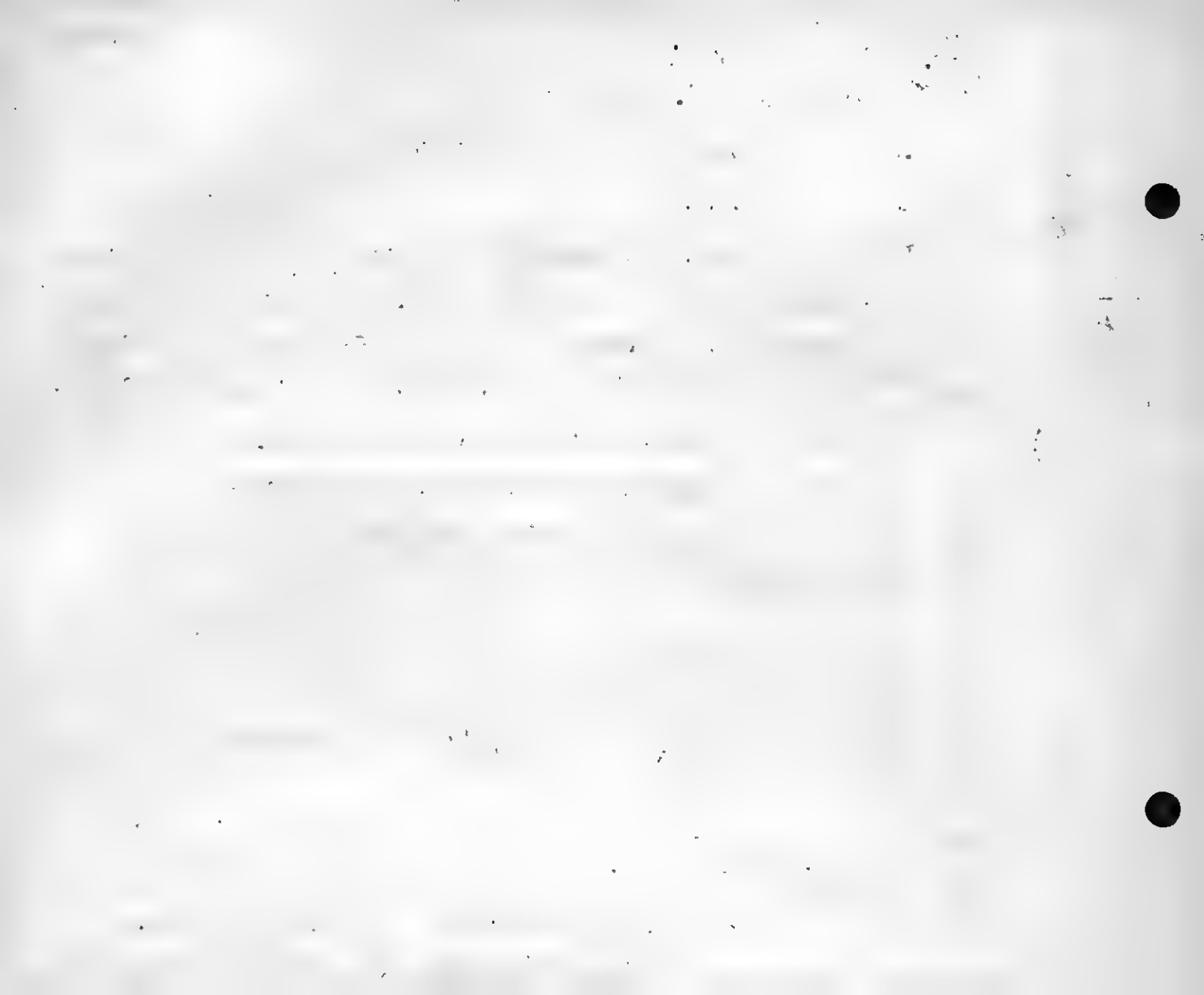


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304M REV 1-68

13970		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13981	
1. DECEASED-NAME (Type or print)		First <b>ROBERT</b>	Middle <b>LEE</b>	Last <b>DONNELLY</b>	2a. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>68</b>		2b. HOUR <b>10:35 PM</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH <b>4/31/98</b>			6. AGE (In years last birthday) <b>70</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY, Md.</b>			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>WATCHMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FORD COMPANY</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTIMORE</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>131 E. Gittings Street</b>			
14. FATHER'S NAME First <b>EDWARD</b> Middle <b>A.</b> Last <b>DONNELLY</b>		15. MOTHER'S MAIDEN NAME First <b>RUTH</b> Middle <b>Rusha</b> Last <b>MORGAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>YES WW I</b>		16b. SOCIAL SECURITY NO. <b>218 09 48 45</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERAL UNDETERMINED ORGANISM</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTASES TO LYMPH NODES, SPINE &amp; CEREBRUM</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ANAPLASTIC CARCINOMA LEFT LUNG</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DIABETES MELLITUS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? <b>NO AUTOPSY</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <b>I</b> (this hospital) attended the deceased from <b>8/12/68</b> , 19__, to <b>10/8/68</b> , 19__, that <b>I</b> (we) last saw the deceased alive on <b>10/8/68</b> , 19__, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Neilon Neilson MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>MC CULLY FUNERAL HOME</b>		25a. REG'D BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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13971

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13982

1 DECEASED NAME (Type or print)		First <b>JOSEPH</b>	Middle <b>ALEXANDER</b>	Last <b>DORSEY</b>	2a DATE OF DEATH Month <b>OCTOBER</b>		Day <b>19</b>	Year <b>1968</b>	2b HOUR <b>12:25</b> P. <b>P.</b>	
3 SEX <b>MALE</b>	4 RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>5 20 07</b>		6. AGE (In years last birthday) <b>61</b> YRS		IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.				
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSP.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>LABORER</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before body was removed) <b>MARYLAND</b>			13b COUNTY <b>BALTIMORE</b>	13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>414 ORCHARD STREET</b>			
14 FATHER'S NAME First <b>BILL</b>			Middle	Last <b>DORSEY</b>	15. MOTHER'S MAIDEN NAME First <b>JULIA</b>			Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or unknown <input checked="" type="checkbox"/> (If yes, give dates of service) <b>WW-II</b>		16b. SOCIAL SECURITY NO <b>217 01 5599</b>		17 INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY <b>582X</b> IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>592X</b> (b) <b>CHRONIC GLOMERULONEPHRITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (1) (this hospital) attended the deceased from <b>MARCH 21</b> , 19 <b>68</b> , to <b>OCT. 19</b> , 19 <b>68</b> , that (2) (we) lost saw the deceased alive on <b>OCT. 19</b> , 19 <b>68</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (not) view the body after death.										
22b. SIGNATURE <b>John D. Talbert M.D.</b>					DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/21/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>					22e ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>			
24. FUNERAL DIRECTOR Name <b>Grace W Halstead</b>					ADDRESS <b>1206 W North Ave.</b>		25a. REC'D BY REGISTRAR <b>HALSTEAD FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13372

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13983

1. DECEASED NAME (Type or print) <b>MELLIE NMM DOSUELL</b>			2a. DATE OF DEATH Month <b>OCT.</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>1:00 PM</b>					
3. SEX <b>F</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>7-1-1908</b>		6. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County,</b> Md.					
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- admission) STATE <b>MD</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1314 LAFAYETTE AVE.</b>	
14. FATHER'S NAME First <b>GEORGE</b> Middle <b>NMM</b> Last <b>JOHNSON</b>			15. MOTHER'S MAIDEN NAME First <b>MOLLIE</b> Middle <b>? UNKN</b> Last <b>? UNKN</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>219-22-5194</b>			17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Miliary tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>2172</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acute uremia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W Newcomer</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>						22e. ADDRESS <b>Mount Wilson, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-9-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Chews Chapel</b>			23d. LOCATION (City or Town) (County) (State) <b>AYNE ARUNDEL Md</b>		
24. FUNERAL DIRECTOR <b>HICKS FUNERAL HOME</b>						ADDRESS <b>BONNAPARTS Md</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		
									25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-perforated pages 1 and 2. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

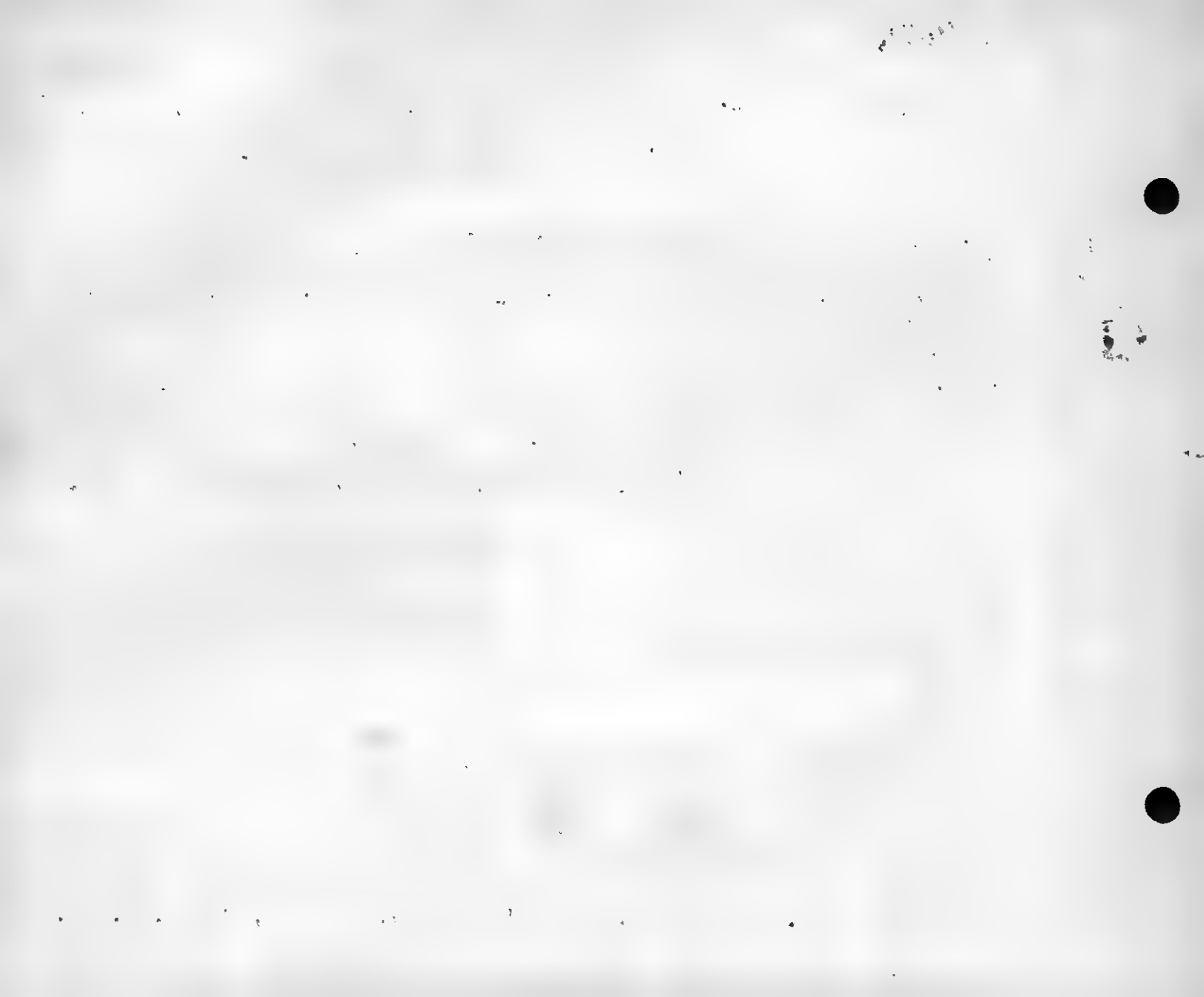
13973

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13984

1. DECEASED-NAME (Type or print) <b>RICHARD J. DOUGLAS</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>10:35 A.M.</b>						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3-13-98</b>		6. AGE (In years last birthday) <b>70</b> YRS.		7. UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>		8. UNDER 24 HRS. HOURS <b>5</b> M. <b>11</b>		
7a. BIRTHPLACE (State or foreign country) <b>J.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.						
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CHESAPEAKE MANICURE HOME 508 E. JORDAN ST. BALTO. CO.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>Baltimore</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Cockeysville</b>		13d. INSIDE CITY (LIMITS)? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>34 PARKS AVE.</b>			
14. FATHER'S NAME First <b>UNKNOWN</b> Middle <b></b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b></b> Last <b></b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>212-46-5682</b>		17. INFORMANT <b>Wife</b>			Address <b>Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>10</b> Day <b>18</b> Year <b>68</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b>21218</b>		City or Town <b>BALTO.</b>		County <b>BALTO.</b>		State <b>Md.</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>Oct 18, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death <b>(I) (we) (did) (did not) view the body after death</b>												
22b. SIGNATURE <b>R K Gundry MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-19-68</b>						
22d. PHYSICIAN'S NAME (Type) <b>R K GUNDY</b>		22e. ADDRESS <b>2 W University Pkwy, #21218</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 21, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		23d. LOCATION (City or Town) <b>Texas, Balto. Co., Md.</b>		(County) <b></b>		(State) <b></b>		
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		ADDRESS <b></b>		25a. REC'D BY REGISTRAR <b>DATE OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

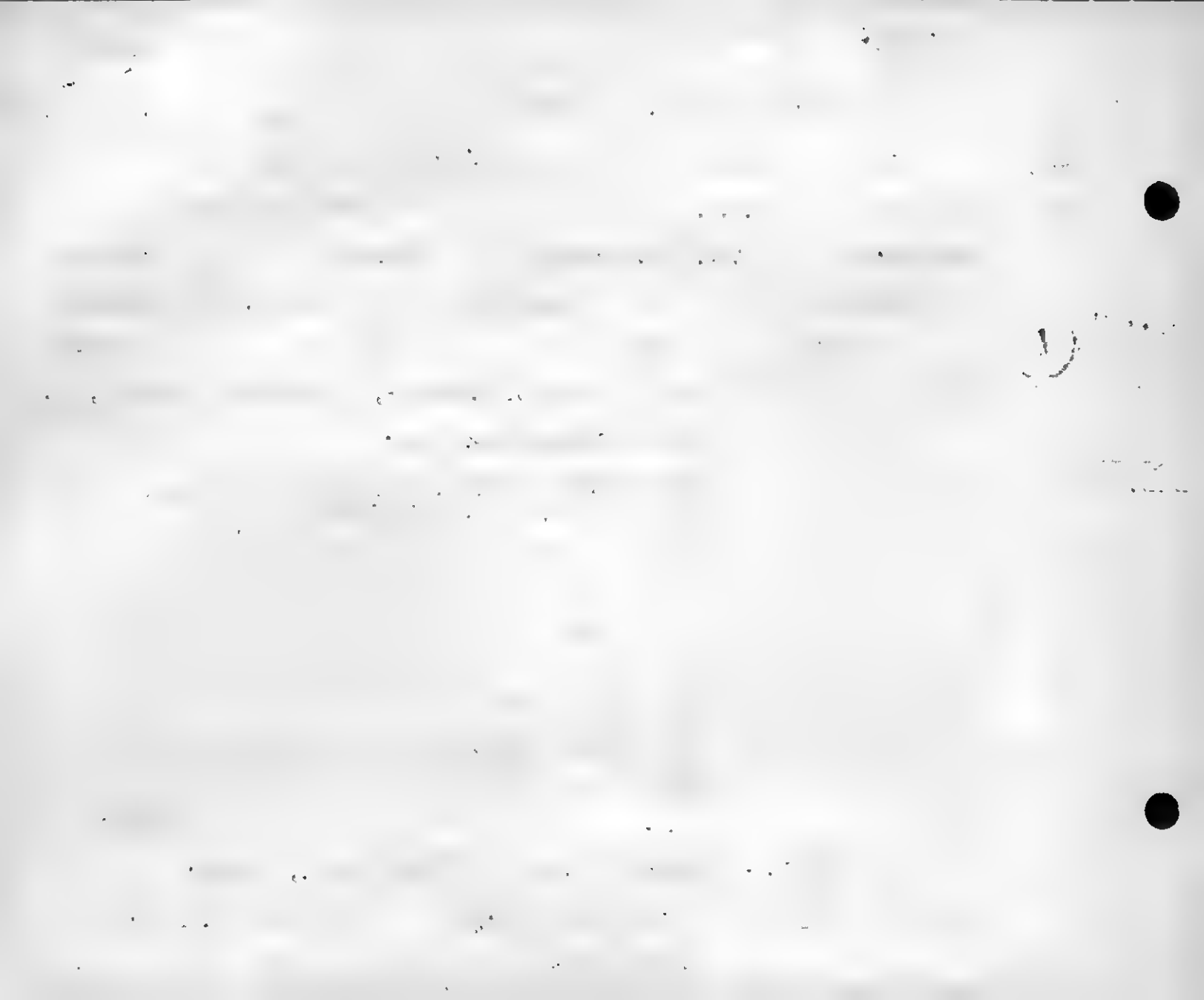
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

13974

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13985

1. DECEASED-NAME (Type or print) <b>RAYMOND R. DOWELL</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>68</b>			2b. HOUR <b>11:30P</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>1/10/95</b>		6. AGE (In years last birthday) <b>73</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR IND. STRY. <b>SHIPYARD</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1623 E. Oliver Street</b>							
14. FATHER'S NAME First <b>BENJAMIN</b> Middle <b>DOWELL</b> Last <b>DOWELL</b>			15. MOTHER'S MAIDEN NAME First <b>FANNY</b> Middle <b>ARMSTRONG</b> Last <b>ARMSTRONG</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name of (unit) <b>YES</b> (If yes give year or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO <b>213 07 09 28</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF <b>ADENOCARCINOMA PANCREAS WITH METASTASIS TO LIVER, OMENTUM AND PERITONEUM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1579</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (he/she) (this hospital) attended the deceased from <b>8/17/68</b> , 19____, to <b>10/14/68</b> , 19____, that (he/she) (we) last saw the deceased alive on <b>10/14/68</b> , 19____, and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above. (he/she) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>George C. McElpatrick M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/15/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>				22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR ADDRESS <b>JOHNSON FUNERAL HOME</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

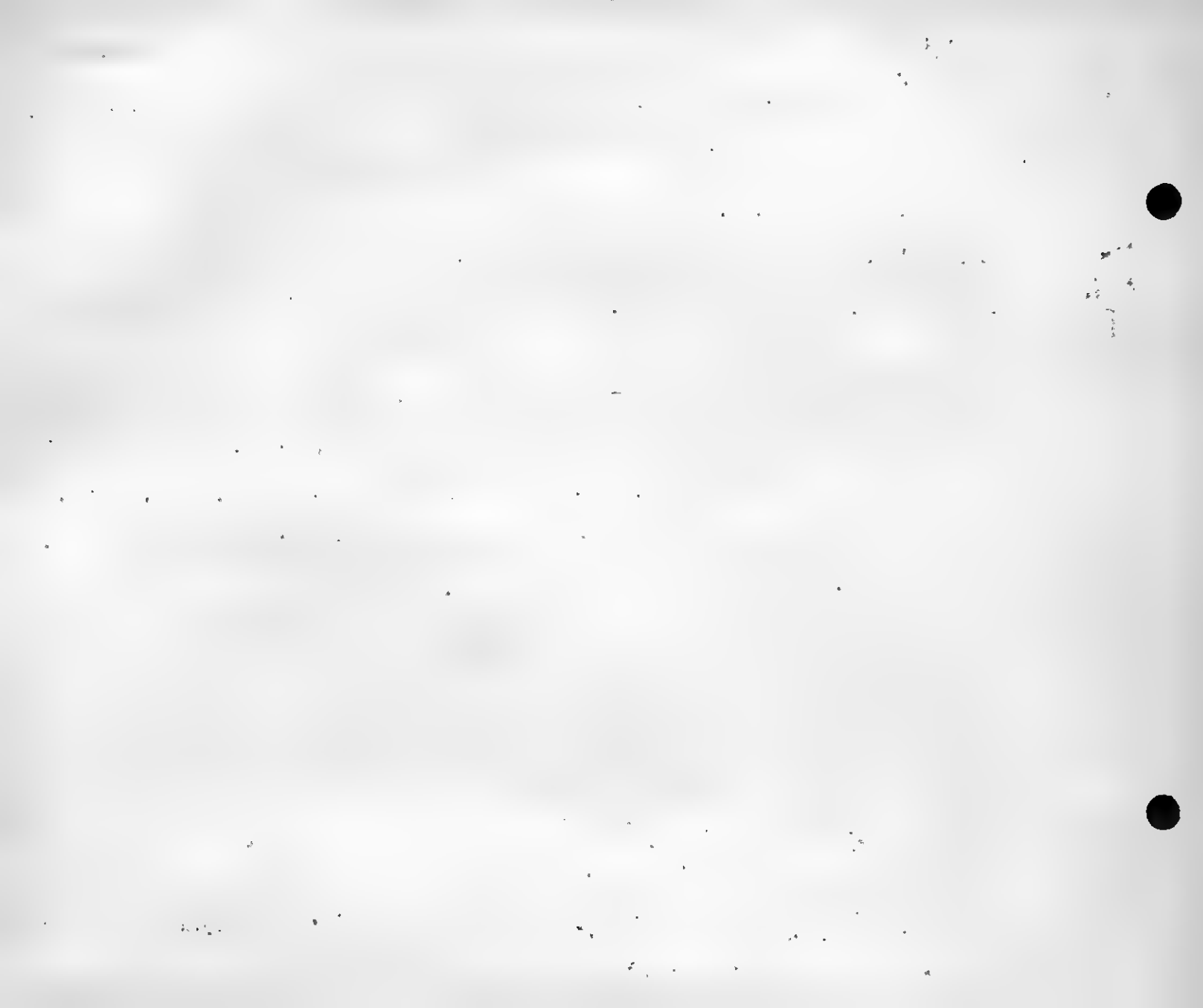


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415  
304 REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Charles		Middle J.		Last Drewer		2a. DATE OF DEATH Month Day Year October 11, 1968		
3. SEX male		4 RACE white		5 DATE OF BIRTH May 17, 1902			6 AGE (In years last birthday) 66 YRS		7 2b. HOUR 7:45 p. M.		
7a BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) cook			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 315 Ingleside Avenue			
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last Griffen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Navy			16b SOCIAL SECURITY NO. 215-03-3437A		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, Death, DUE TO, OR AS A CONSEQUENCE OF with chronic atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic, Cardiovascular Ht. Dis. 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, Senile 1 yrs. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Thrombophlebitis, chronic, left leg.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from March 6 19 68, to Oct. 11, 19 68, that (X) (we) last saw the deceased alive on Oct. 11 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE <i>Anthony J. Young</i>						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 10-14-68	
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.						22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 16 1968		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery			23d. LOCATION (City or Town) (County) (State) Ritchie Highway A A Md				
24 FUNERAL DIRECTOR Krause Funeral Home		ADDRESS 12165 Charles St		25a. RECD BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13976

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13987

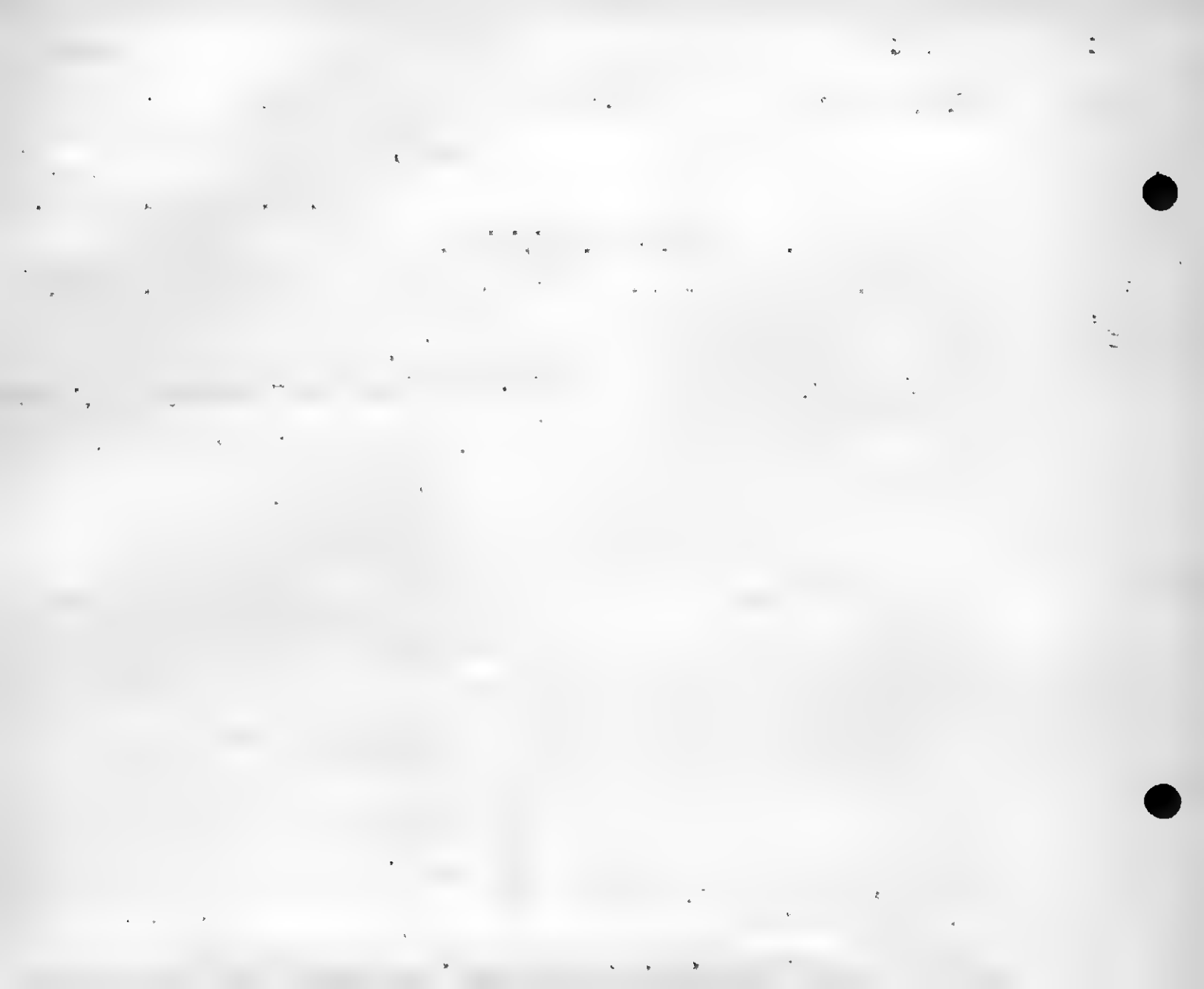
1. DECEASED-NAME (Type or print)		First CHARLES		Middle A.		Last DuVALL		2a. DATE OF DEATH Month October		Day 1		Year 1968		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 2, 1883		6. AGE (In years lost birthday) 85		IF UNDER 1 YEAR MONTHS		DAYS		IF UNDER 24 HRS HOURS		MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore									
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Caton Ridge Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4138 Wilkens Avenue							
14. FATHER'S NAME First Stiers		Middle DuVall		Last		15. MOTHER'S MAIDEN NAME First Armynella		Middle (Unknown)		Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Robert E. Bingel		Address 4138 Wilkens Ave.						21229	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sanguine left lower extremity (compartment)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown Cause</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4.5 x</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>7</u> , 19 <u>68</u> , to <u>02</u> , 19 <u>68</u> , that (I) <u>was</u> lost saw the deceased alive on <u>Jan 1</u> , 19 <u>68</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (do not) view the body after death															
22b. SIGNATURE <u>James Nolan</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/3/68									
22d. PHYSICIAN'S NAME (Type) Dr. James J. Nolan		22e. ADDRESS 1 Mallow Hill Road, Balto., Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-4-1968		23c. NAME OF CEMETERY OR CREMATORY Jennings Chapel Cemetery		23d. LOCATION (City or Town) Woodbine, Maryland		(County)		(State)					
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR DATE OCT 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
13988									
1. DECEASED NAME First Middle Last <b>13577 Benjamin A Earnshaw</b>			2a. DATE OF DEATH Month Day Year <b>October 14 68</b>			2b. HOUR <b>1:10 A</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>July 1, 1916</b>		6. AGE (in years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>21133 Balto. Co. Randallstown Md.</b>			
10. CITY OR TOWN OF DEATH <b>Randallstown Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If at hospital give street address) <b>D.O.A. Baltimore Co. Gen. Hospt.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>30 Millstone Rd. Hgts.</b>	
14. FATHER'S NAME First Middle Last <b>JOHN FRANCIS EARNSHAW</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>LILLIAN GARRETT</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWT 214-10-0777</b>		17. INFORMANT Address <b>Mrs. Patricia Earnshaw 30 Millstone Rd. Hgts. 21133</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio sclerosis -</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Indef.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>10/14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Morton J. Ellin, M.D.</b>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>8629 Liberty Road, Randallstown, Md.</b>		22e. DATE SIGNED <b>10/14/68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>OCT. 16, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW MEMORIAL</b>		23d. LOCATION (City or Town) (County) (State) <b>LIBERTY RD. BALTO. CO. MD.</b>			
24. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. Randallstown Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PW-6, Page 5 may be retained for your files.

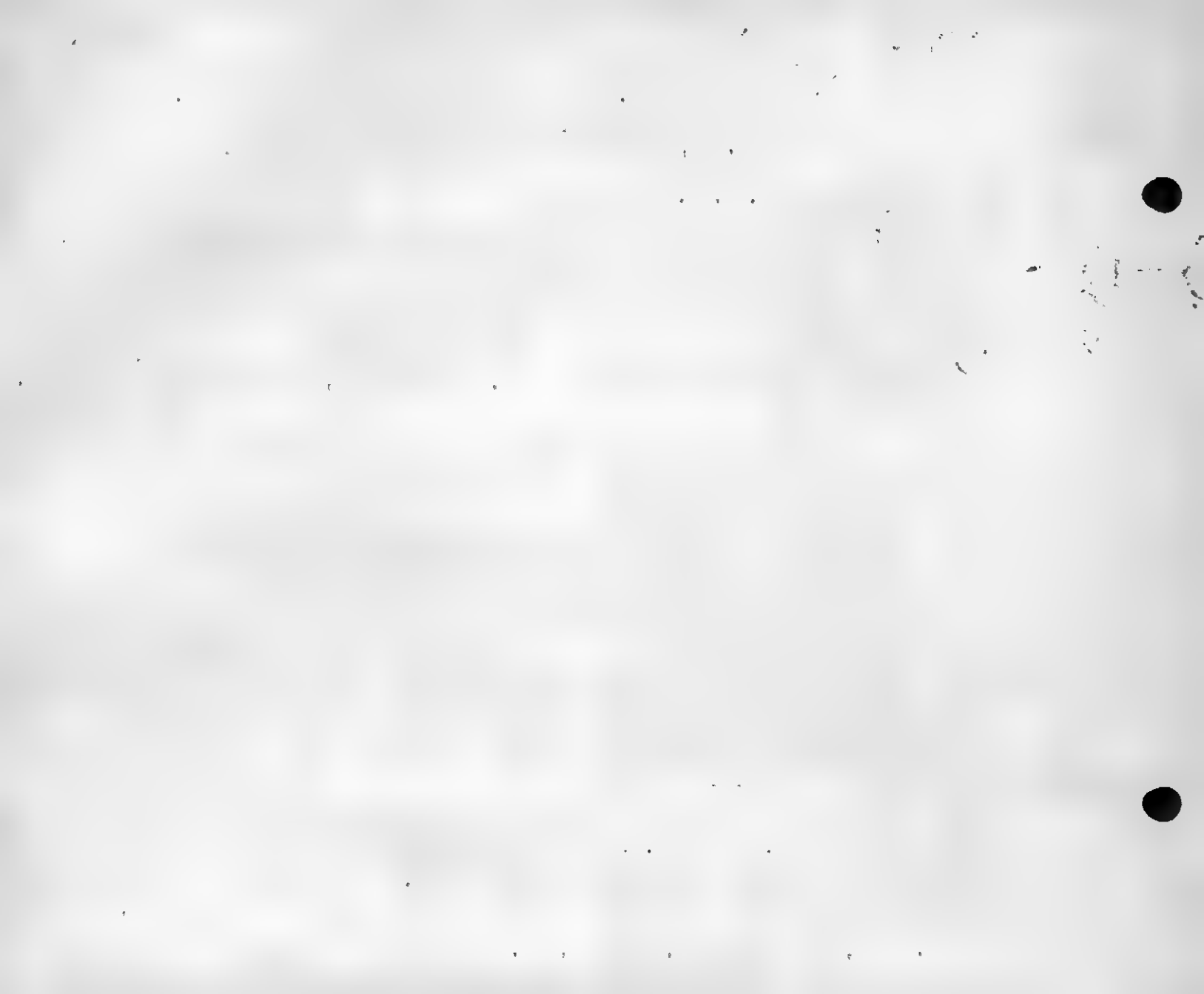
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13975

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13989

1 DECEASED NAME (Type or Print) <b>EDWARD</b>			First Middle Last <b>R. EDELBURG</b>			2a DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> MATED <input type="checkbox"/> <b>Oct. 12, 1968</b>			2b HOUR <b>1:45P</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Sept. 17, 1907</b>		6 AGE (in years last birthday) <b>61</b> YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		F UNDER 24 HRS HOURS <input type="checkbox"/> M.N. <input type="checkbox"/>		
7a BIRTHPLACE (State or foreign country) <b>Illinois</b>			7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Baltimore</b>			
10 CITY OR TOWN OF DEATH <b>Dundalk</b>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>813 East Ave.</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Pipefitter</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Continental Can</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Dundalk</b>		13d INSIDE CITY LIM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>1813 East Avenue</b>		
14. FATHER'S NAME First Middle Last <b>Edward Edelburg</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Caroline Teffs</b>				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>No</b> (If yes give war or dates of service)				
16b SOCIAL SECURITY NO <b>284-09-5074</b>				17 INFORMANT (Step-daughter) <b>Mrs. Anna Klinger, 4622 O'Donnell St. Balto.</b>				ADDRESS <b>Md. 21224</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fatty Liver</b> <b>71.8</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <b>October 13, 1968</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>10/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Lutheran Church</b>			23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24 FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>						ADDRESS		25a REC'D BY REGISTRAR DATE <b>OCT 16 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**1397#** **CERTIFICATE OF DEATH** **13990**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>19 Northwood Drive</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> d. STREET ADDRESS <b>19 Northwood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ludwig</b> Middle <b>Eger</b> Last 4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>1968</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Nov. 16, 1909</b> 9. AGE (in years last birthday) <b>58</b> yrs. IF UNDER 1 YEAR: Months <b>5</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR SHIPPING - RET.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; D. Mfg. Co.</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William H. Eger</b> 14. MOTHER'S MAIDEN NAME <b>Mary Koellner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b> 16. SOCIAL SECURITY NO. <b>Family records</b> 17. INFORMANT <b>Family records</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1962</b> to <b>Oct. 20, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 20, 1968</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Laurence C. Post</b> 22b. PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b> 22c. ADDRESS <b>6805 York Rd Baltimore Md</b> 22d. DATE SIGNED <b>10/22/68</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Oct. 23, 1968</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Jessops Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Cockeysville, Maryland</b>		24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b> 25a. REC'D BY REGISTRAR <b>OCT 24 1968</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

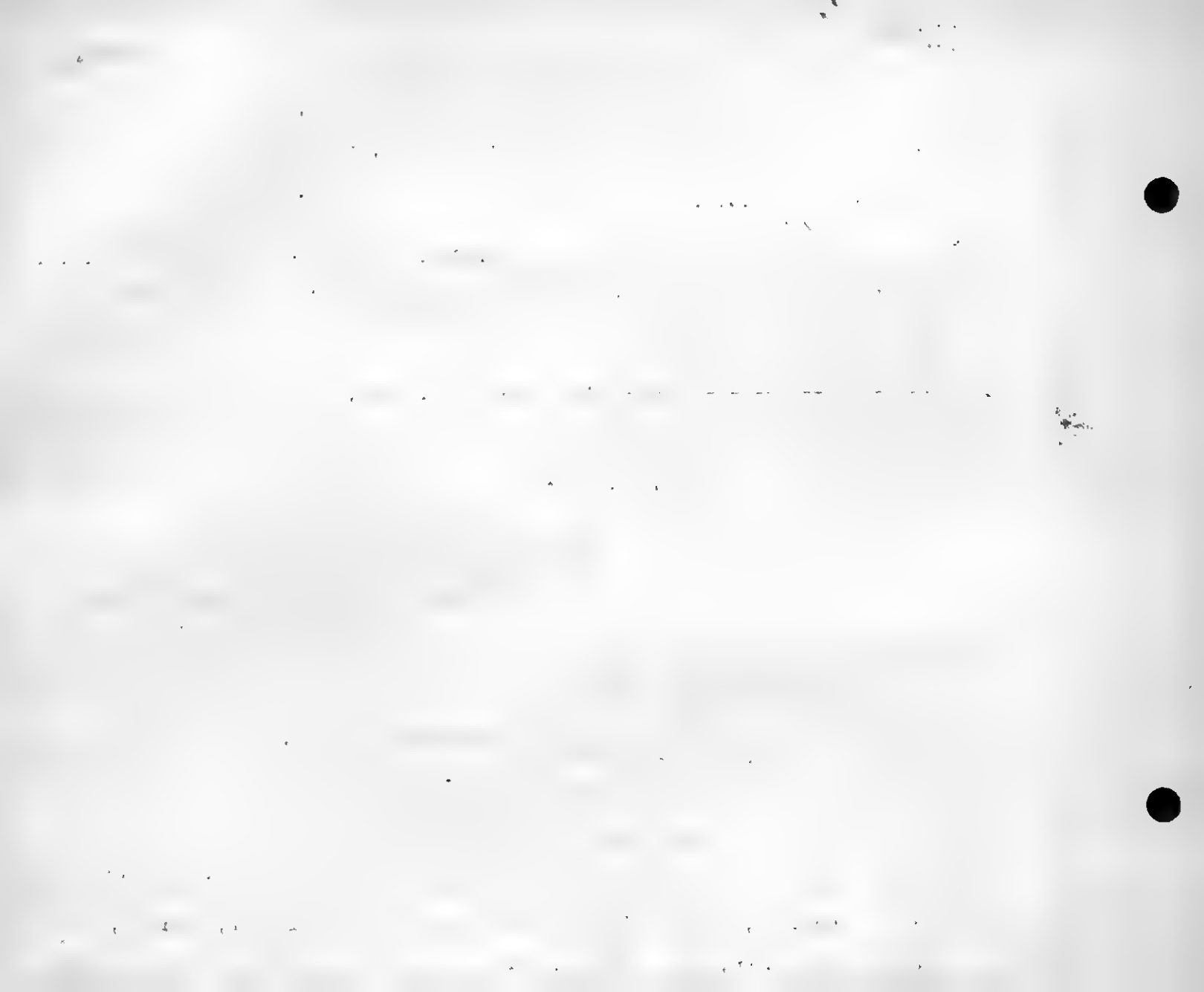


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV 64

139980												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												139991											
1 DECEASED-NAME (Type or print)												2a. DATE OF DEATH												2b. HOUR											
MARGARET IDA EKIN												10 Month 8 Day 68 Year												7:55 M											
3 SEX				4 RACE				5 DATE OF BIRTH				6 AGE (In years last birthday)				IF UNDER 1 YEAR MONTHS				IF UNDER 24 HRS HOURS				MIN											
Female				White				September 16, 1904				64 YRS.																							
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
Maryland				U.S.A.								Baltimore,																							
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY																							
Baltimore, Maryland				Greater Baltimore Med. Ctr.				Homemaker				U.S.A.																							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIM TS?				13e STREET AND NUMBER																			
Maryland				Baltimore				Towson				YES <input type="checkbox"/> NO <input type="checkbox"/>				# 540 Valley View																			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																															
John Thomas Roop				Ida Lescaleett																															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16b. SOCIAL SECURITY NO				17 INFORMANT				Address																							
No				219-20-6643				Kenneth H. Ekin,				Same as # 13																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>																																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2022</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized malignant lymphoma</u>																																			
DUE TO, OR AS A CONSEQUENCE OF (c) _____																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>XU-X</u>																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				Yes																							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)																											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 30, 1968</u> , to <u>Oct 8, 1968</u> , that (I) (we) lost the deceased alive on <u>Oct 8, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE				22c. DATE SIGNED																															
<u>Charles C. Brown, M.D.</u>				10/8/68																															
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS																															
Charles C. Brown, M.D.				Greater Baltimore Medical Center																															
23a BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)																							
Burial				Oct. 10, 1968				Meadow Branch Cemetery				Westminster, Carroll, Maryland																							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																											
Wm. Cook-Brooks Towson, 1050 York Rd. 21204				DATE				OCT 9 1968				<u>Charles Judge</u>																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13981

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13992

1. DECEASED-NAME (Type or print) <b>PAUL Phillip Elchenko</b>			2a. DATE OF DEATH 10 Month 8 Day 68 Year			2b. HOUR 4.45 P.M.			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH 2/16/1888		6. AGE (In years lost birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO</b>			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1409 Frederick Rd</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>NIGHT WATCHMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE of Md.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1409 Frederick Rd</b>	
14. FATHER'S NAME First Middle Last <b>Phillip Elchenko</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>285-01-3746A</b>		17. INFORMANT <b>Mrs Glenn D. Steele</b>		Address <b>1409 Frederick Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of gall bladder with metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months +</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1001</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 to <b>Oct 8</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Oct 8</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John A. Nesbitt, Jr</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10-9-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR</b>				22e. ADDRESS <b>1009 Frederick Rd, Baltimore Md 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/11/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO MD</b>			
24. FUNERAL DIRECTOR <b>Charles Nabbe</b>				ADDRESS <b>301 Frederick Rd</b>		25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

13982

CERTIFICATE OF DEATH

13993

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Mary		Hubert	Cowan	Ennis	October 27, 1968		M	
3. SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White		April 12, 1878		90 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Delaware	U.S.A.				Baltimore Md.			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson	Towson Convalescent Home		Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland	Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		942 Dulaney Valley Road 301 W. Chesapeake Ave.	
14 FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Andrew	S.	Cowan		Mary		G.	Hubert	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No		220-46-9918		Mr. Dawson L. Farber Jr.		614 Chesnut Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intensive selective cardiac vascular disease</u>								10 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Quinoides fibrillation</u>								10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary heart failure</u>								3 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized osteoarthritis</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>27 Oct</u> , 19 <u>68</u> , that (I) <u>(we)</u> lost the deceased alive on <u>23 Oct</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.								
22b. SIGNATURE <u>E. S. Cross Jr.</u>				22c. DATE SIGNED <u>28 Oct '68</u>		22d. PHYSICIAN'S NAME (Type) <u>ERNEST S. CROSS JR.</u>		
				22e. ADDRESS <u>803 MED. ARTS. Bldg</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		10/29/68		Loudon Park Cemetery		Baltimore, Maryland		
24. FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Wm. Cook-Brooks Towson 1050 York Rd. 21204						DATE <u>OCT 30 1968</u>		<u>Charles Judge</u>



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13988

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13994

1. DECEASED-NAME (Type or print) <b>JOHN HOWARD JR. ERDMAN</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>68</b>			2b. HOUR <b>9:30 P M</b>	
3. SEX <b>Male</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>3-18-68</b>		6. AGE (in years last birthday) <b>6 MO YRS.</b>	
7a. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>G. B. M. C.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>JOHN</b>		14. FATHER'S NAME Middle <b>H.</b>		14. FATHER'S NAME Last <b>ERDMAN</b>		15. MOTHER'S MAIDEN NAME First <b>CROWTHER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mr. John H. Erdman, Sr.</b>		17. INFORMANT Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>2750</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>hepatocellular failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>poss. cystic fibrosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>2750</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> , 19 <b>68</b> , to <b>10/9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. F. NIKEL</b>				22c. DATE SIGNED <b>10/19/68</b>		22d. PHYSICIAN'S NAME (Type) <b>A. F. NIKEL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/11/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>				25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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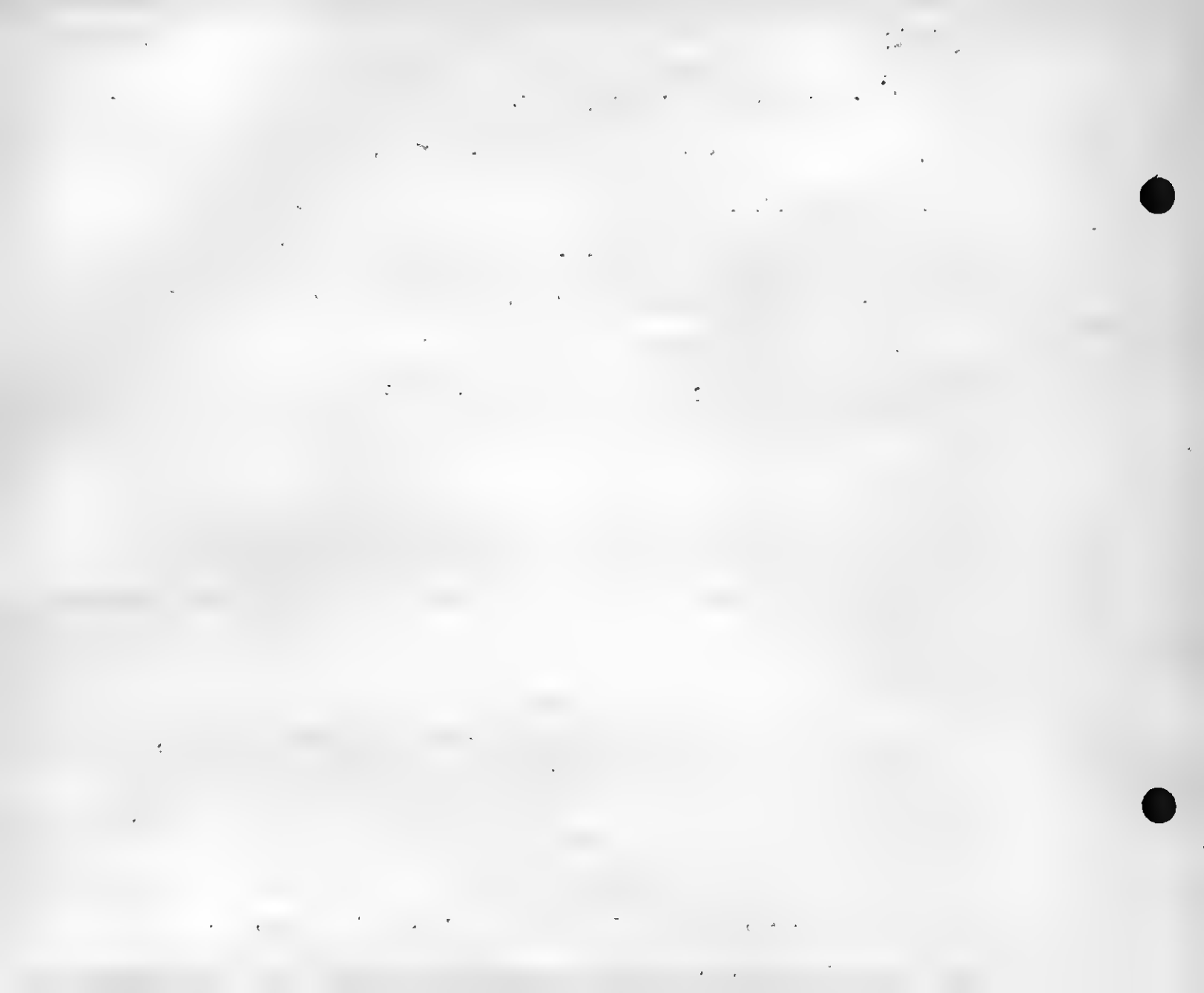
13984

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13995

1. DECEASED-NAME (Type or print) <b>GETTINGS</b>			First Middle Last <b>WILLIAM ERNEST</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>68</b>			2b. HOUR <b>5:05A</b>		
3. SEX <b>MALE</b>			4. RACE <b>Cau.</b>			5. DATE OF BIRTH <b>November 30, 1903</b>			6. AGE (In years last birthday) <b>64</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>G.B.M.C.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Ship Pilot</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Towson</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>730 Charing Terrace</b>			14. FATHER'S NAME First Middle Last <b>Charles William Ernest</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Annie Gettings</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>215-32-9698</b>			17. INFORMANT Address <b>Agnes F. Ernest, Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXTENSIVE METASTATIC CA SPINE</b> <b>1702</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1702</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> , 19 <b>68</b> , to <b>10/26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Neeraja Thakur</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>10/26/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>NEERAJA THAKUR, M.D.</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>Oct. 29, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Md.</b>		
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Rd., Towson</b>						25a. REC'D BY REGISTRAR <b>DA OCT 29 1968</b>			25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>		



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VR A15  
304A REV 1-60

13985

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13996

1. DECEASED NAME (Type or print) <b>SALLIE R. ESSIG</b>			2a. DATE OF DEATH <b>10</b> Month <b>15</b> Day <b>68</b> Year			2b. HOUR <b>4:55</b> A.M.			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3/29/95</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO</b>			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SHARP WOOD</b>		12a. US/JAT OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. US/JAT RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3e. STREET AND NUMBER <b>1006 MACAULDER AVE</b>	
14. FATHER'S NAME <b>JOHN RENEHAN</b>			15. MOTHER'S MAIDEN NAME <b>MARY HENNESSY</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
17. INFORMANT <b>MRS MARK E. KERGER</b>			18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Hepatitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 weeks</b>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>arteriosclerotic hypertensive cardiovascular</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 20</b> , 19 <b>67</b> , to <b>Oct. 15</b> , 19 <b>68</b> , that (I) (we) <del>last</del> saw the deceased alive on <b>Oct 14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <del>did</del> (did not) view the body after death.									
22b. SIGNATURE <b>John A. Nesbitt, Jr.</b>				22c. DATE SIGNED <b>10-16-68</b>		22d. PHYSICIAN'S NAME (Type) <b>John A. Nesbitt, Jr.</b>			
22e. ADDRESS <b>1009 Frederick Road</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO MD</b>			
24. FUNERAL DIRECTOR <b>E.S. MACNABB</b>				25a. REC'D BY REGISTRAR <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





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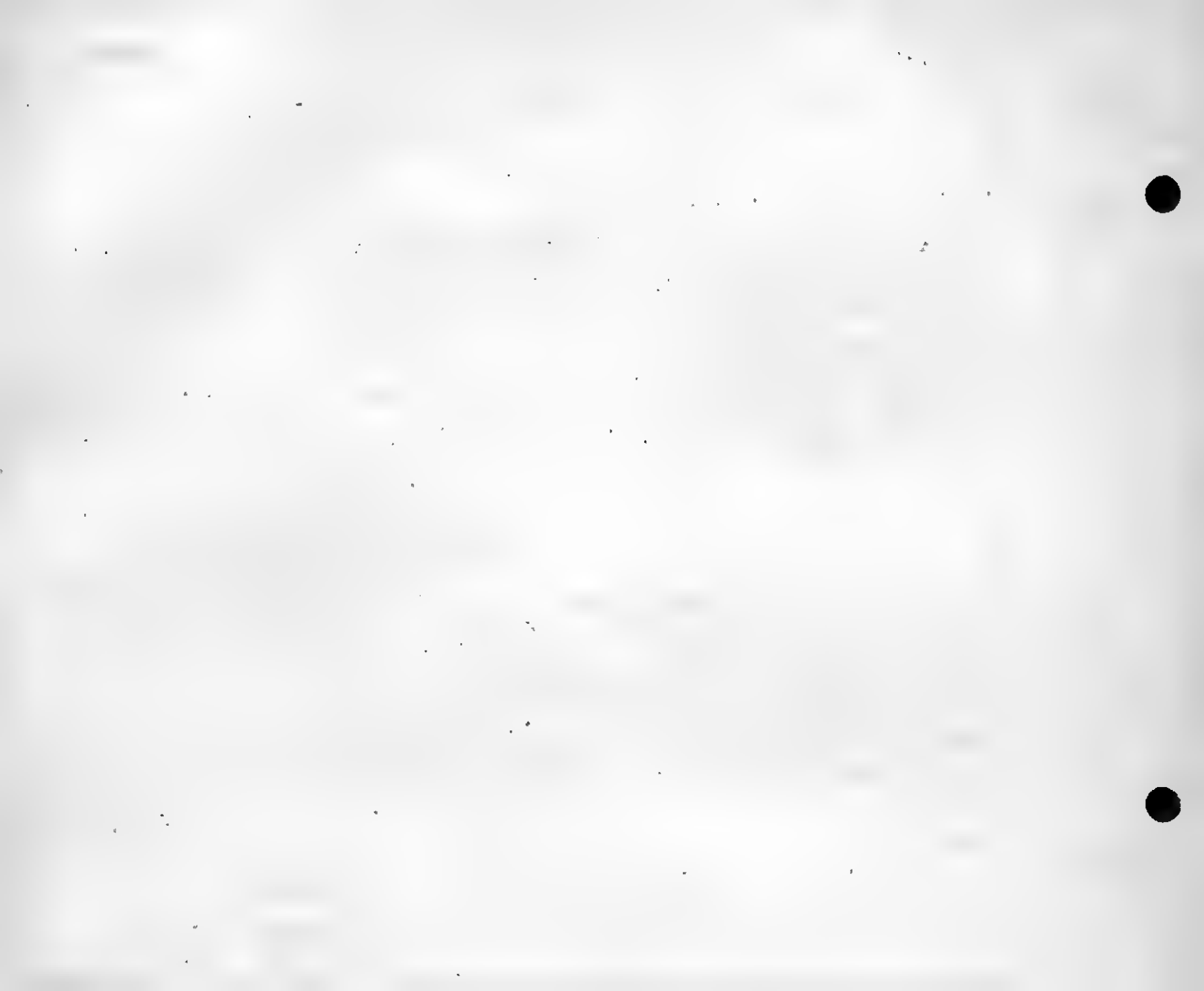
13988

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13997

1. DECEASED-NAME (Type or print) <b>JOHN</b>			First <b>JOHN</b> Middle <b>E.</b> Last <b>EWING</b>			2a. DATE OF DEATH October <b>18</b> Day Year <b>1968</b>			2b. HOUR <b>8</b> MIN <b>00</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 17, 1915</b>			6 AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>			Md.			
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6746 Woodley Road</b>			12a. US. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Leader</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Welding rods</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>6746 Woodley Road</b>					
14. FATHER'S NAME First <b>James</b> Middle <b>Ewing</b> Last <b>Ewing</b>				15. MOTHER'S MAIDEN NAME First <b>Dorothy</b> Middle <b>Ohler</b> Last <b>Ohler</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>212-18-3073</b>		17. INFORMANT Address <b>Mrs. Vera Ewing, 6746 Woodley Road</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A-S-C-V-Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17, 1968</b> , to <b>Oct. 18, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Oct. 17, 1968</b> , and that in <del>(my)</del> <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.													
22b. SIGNATURE <b>M.B. Davis</b> <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <b>10/20/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>M.B. Davis, M.D.</b>						22e. ADDRESS <b>6800 Mornington Road. - 21222</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 21, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Md.</b>						
24. FUNERAL DIRECTOR <b>Ulrich Funeral Home Dundalk, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



13987

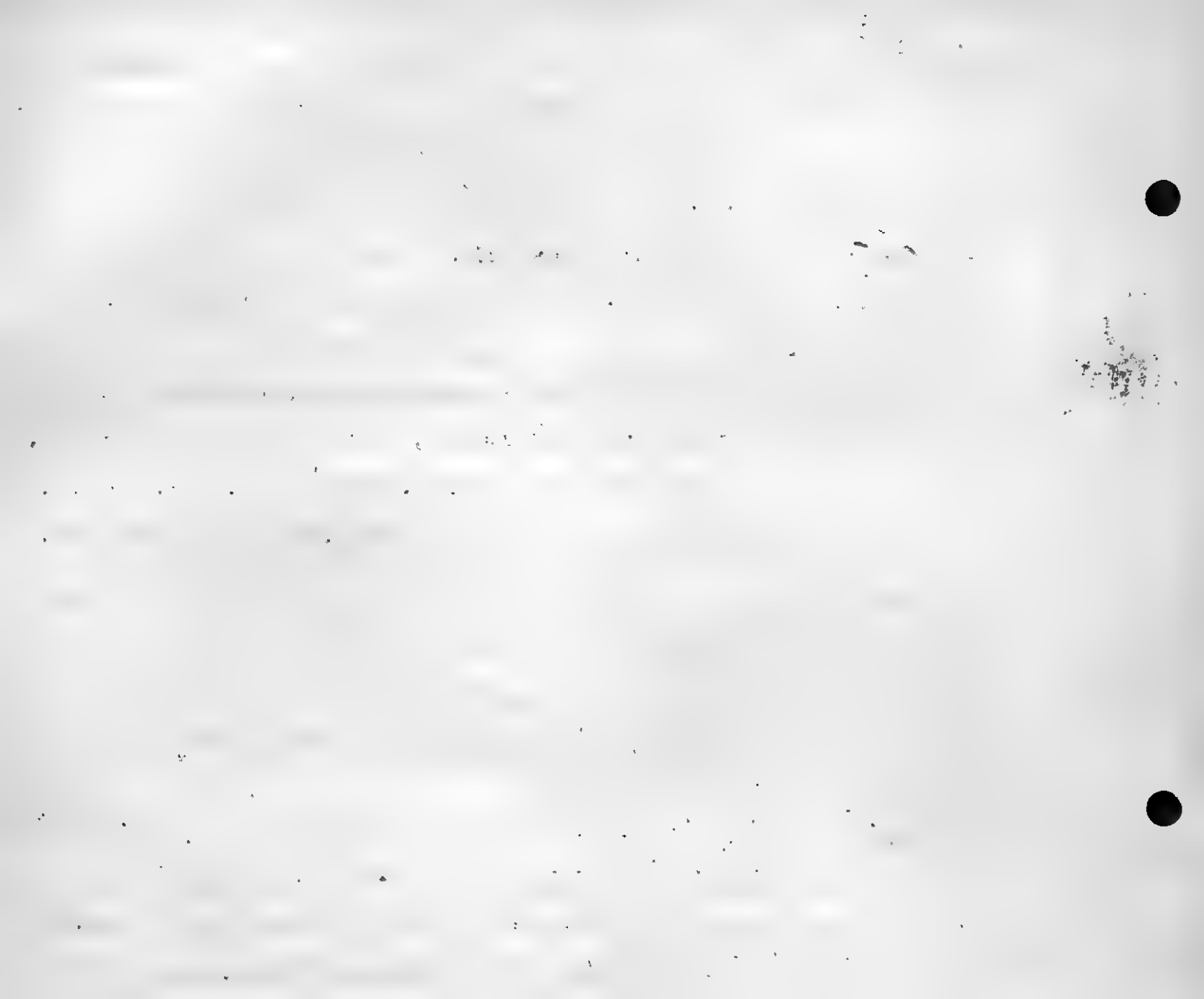
## CERTIFICATE OF DEATH

13998

1. DECEASED-NAME (Type or print) <b>Anna E Fairchild</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR <b>4:20</b> P.M.	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>July 27, 1877</b>		6. AGE (In years last birthday) <b>91</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Oxen Hill</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Thomas Harrison</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Elijah UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>212-56-2381</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute, death</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours.</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, Generalized, Senile</b>							<b>10 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <b>Dec. 20, 1967</b> to <b>Oct. 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct. 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Anthony J. Young</i> DEGREE				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10/1/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>		23b. DATE <b>10-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Calver Manor Md.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co</b> <b>8655 So. Ave. Silver Spring Md</b>				25a. REC'D BY REGISTRAR <b>OCT 4 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1

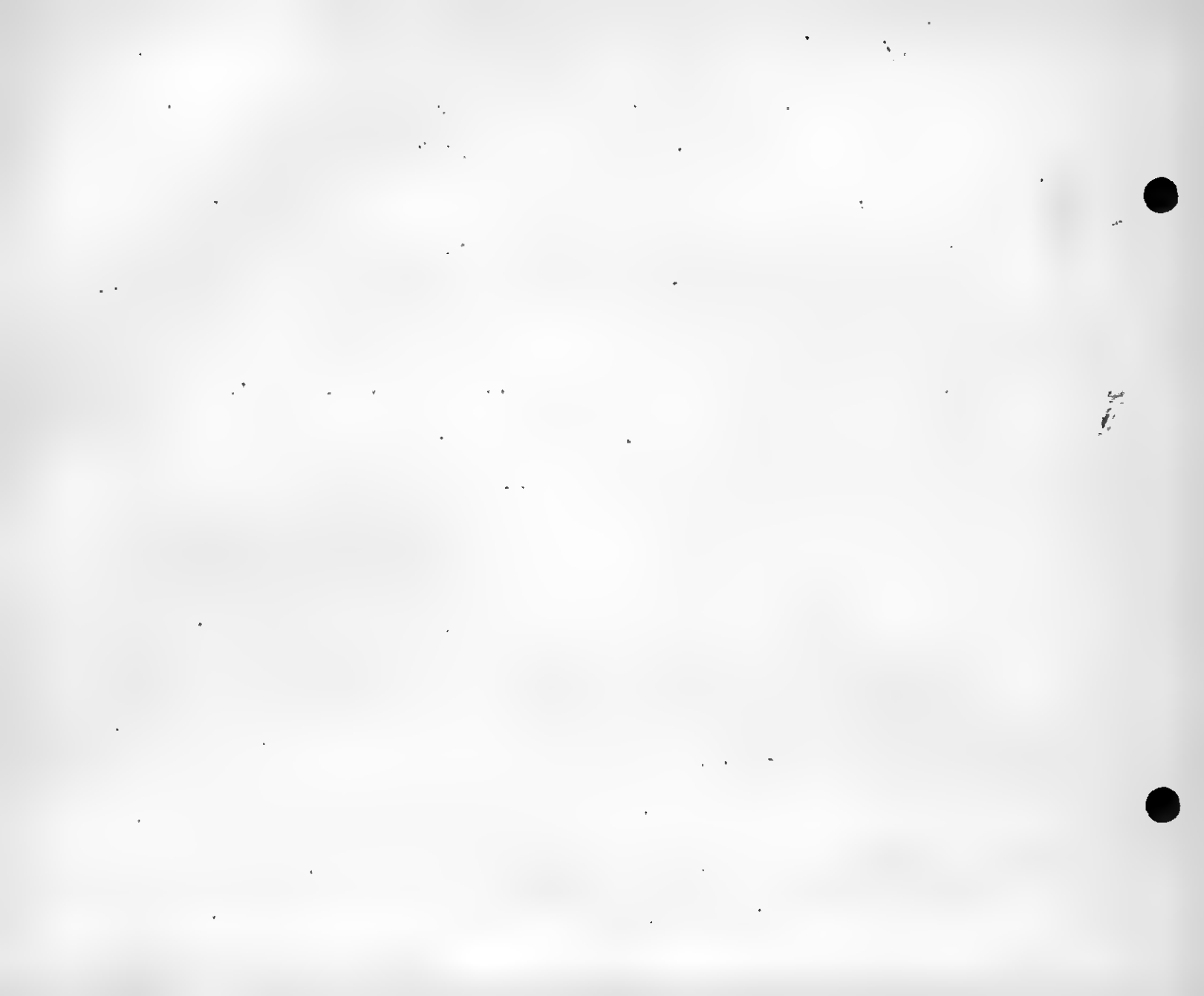
13988

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13999

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR A		
Hanson (Fauntleroy)					Fauntleroy	10 Month 9 Day 68 Year			2:30 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
Male		Negro		8/28/05		63 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		U.S.A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore				Greater Balto. Med. Center							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.				Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>		1550 N. Charles St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Unk.						Lottie Ann					Fauntleroy
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes; no, or unknown?				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
				12-03-7440		Mrs. Mary B. Fauntleroy, 1550 N. Charles St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u>											
1517 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Carcinoma of pancreas</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1577											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/23</u> , 19 <u>68</u> , to <u>10/9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
<i>Rudiger Breiteneker</i>								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		10/9/68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS			
Rudiger Breiteneker, M.D.								6701 N. Charles Street			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		10-12-68		Mount Auburn Cem.		Baltimore,		Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
1701 Laurens St.						OCT 11 1968		<i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

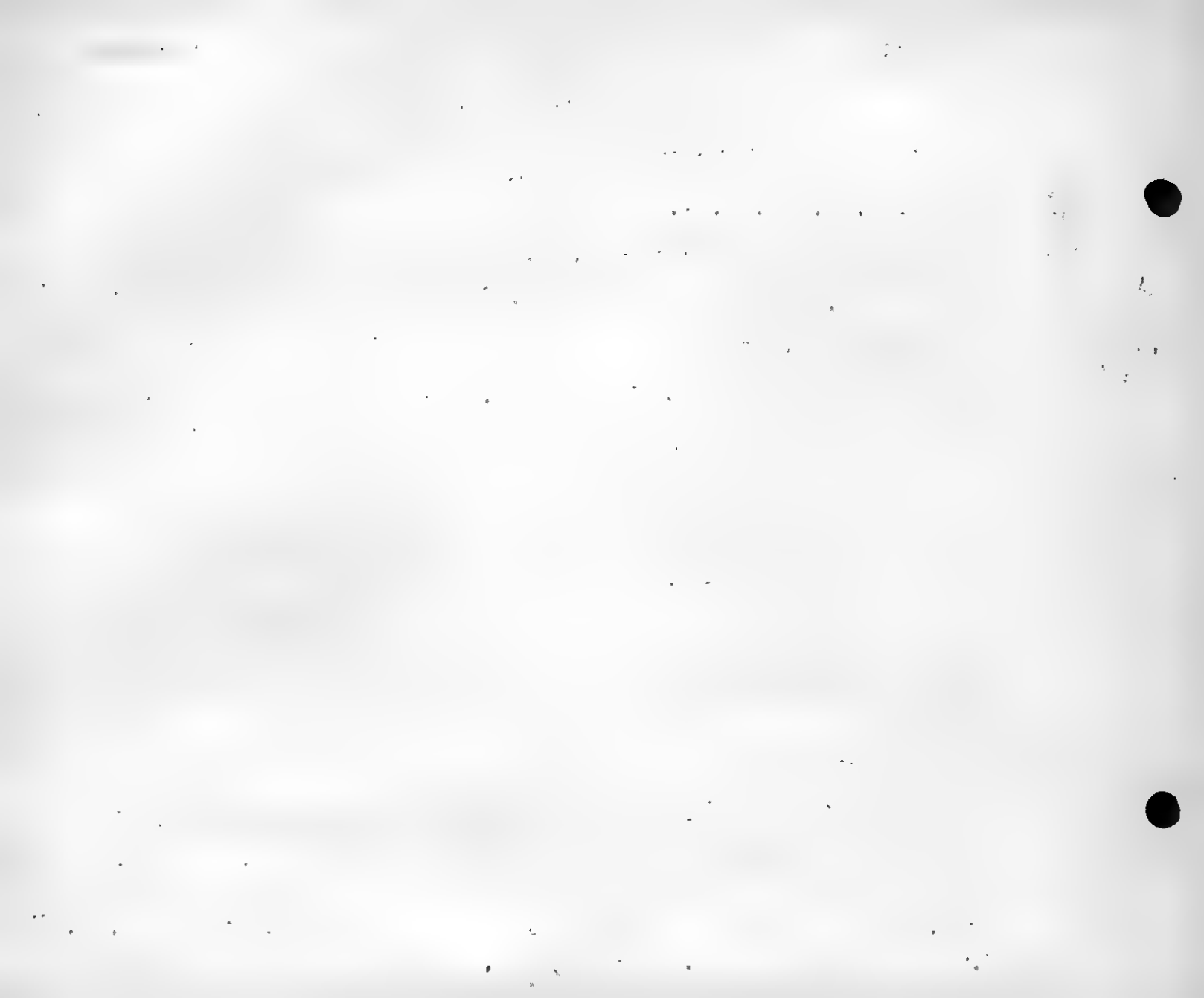
13985

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14000

1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
ALEXANDER				LITTLEJOHN		Month 10 Day 10 Year 1968			1:10am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. UNDER YEAR MONTHS		8. UNDER 24 HRS. DAYS HOURS MIN	
Male		Caucasian		11/14/1890		77 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Oxford, N. C.		U. S. A.				Baltimore Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Towson		Greater Balto. Med. Center		Retired Metallurgist Armco							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Balto. 12				218 Goodale Road			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Alexander J. Feild						Louise					Hughes
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address							
No		218-01-6300		Mrs. Ethel McKeel Feild (Same)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease											
4120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
443X Laennec's cirrhosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10/3, 1968, to 10/10, 1968, that (I) (we) last saw the deceased alive on 10/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Rudiger Breiteneker, M. D.										10/10/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
		Greater Baltimore Medical Center									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		10/12/68		Druid Ridge		Pikesville Balto. Co., Md.					
24. FUNERAL DIRECTOR		H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						DATE OCT 11 1968		Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 1-68  
30M REV 1-68

13890

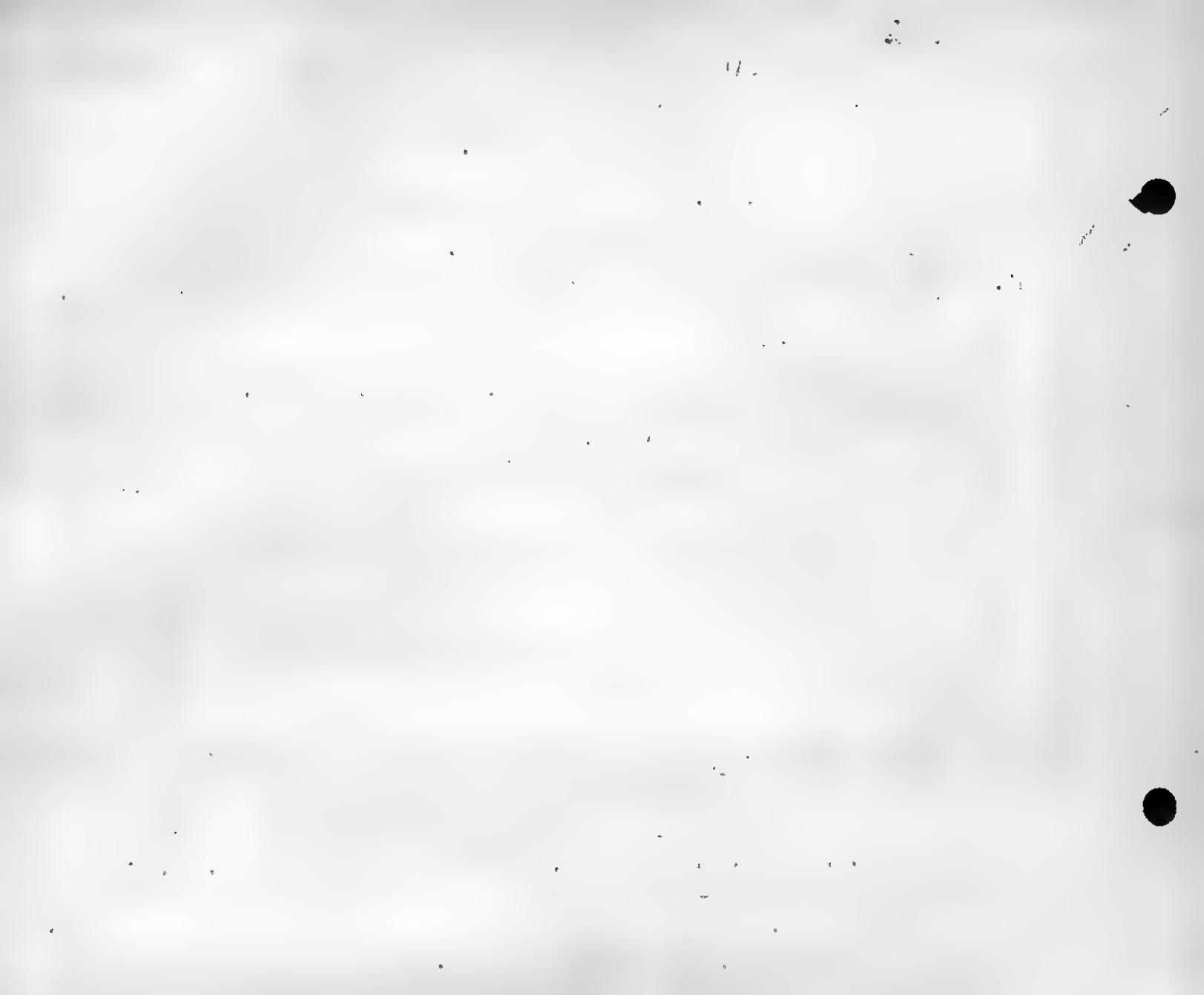
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 6 Film 6435

CERTIFICATE OF DEATH

14001



1. DECEASED-NAME (Type or print) <i>Elisabeth C. Fischer</i>			2a. DATE OF DEATH Oct Month 3 Day 1968			2b. HOUR M			
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH Oct. 14, 1876		6. AGE (In years last birthday) 91 1/2 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>			
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5505 Windsor Mill Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>		13b. CITY <i>Baltimore</i>		13c. CITY OR TOWN <i>Woodlawn</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>5505 Windsor Mill Rd.</i>	
14. FATHER'S NAME First Middle Last <i>Johannes Ulrich</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Babetta Ulrich</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Mrs. Fredia H. Fischer, 5505 Windsor Mill Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>  <i>15 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) this hospital attended the deceased from <i>1960</i> , to <i>October</i> , 19 <i>68</i> , that (I) <i>we</i> lost saw the deceased alive on <i>August 30</i> , 19 <i>68</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>we</i> (did) (did not) view the body after death.									
22b. SIGNATURE <i>M.T. Trauband, Jr.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <i>M.T. Trauband, Jr.</i>		22e. ADDRESS <i>M.D. 1811 N. Rolling Rd. Balt. Md. 21207</i>		22c. DATE SIGNED <i>10/4/68</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 5, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR <i>John T. Stansbury, Sr.</i>		ADDRESS <i>6411 Windsor Mill Rd.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATE ON



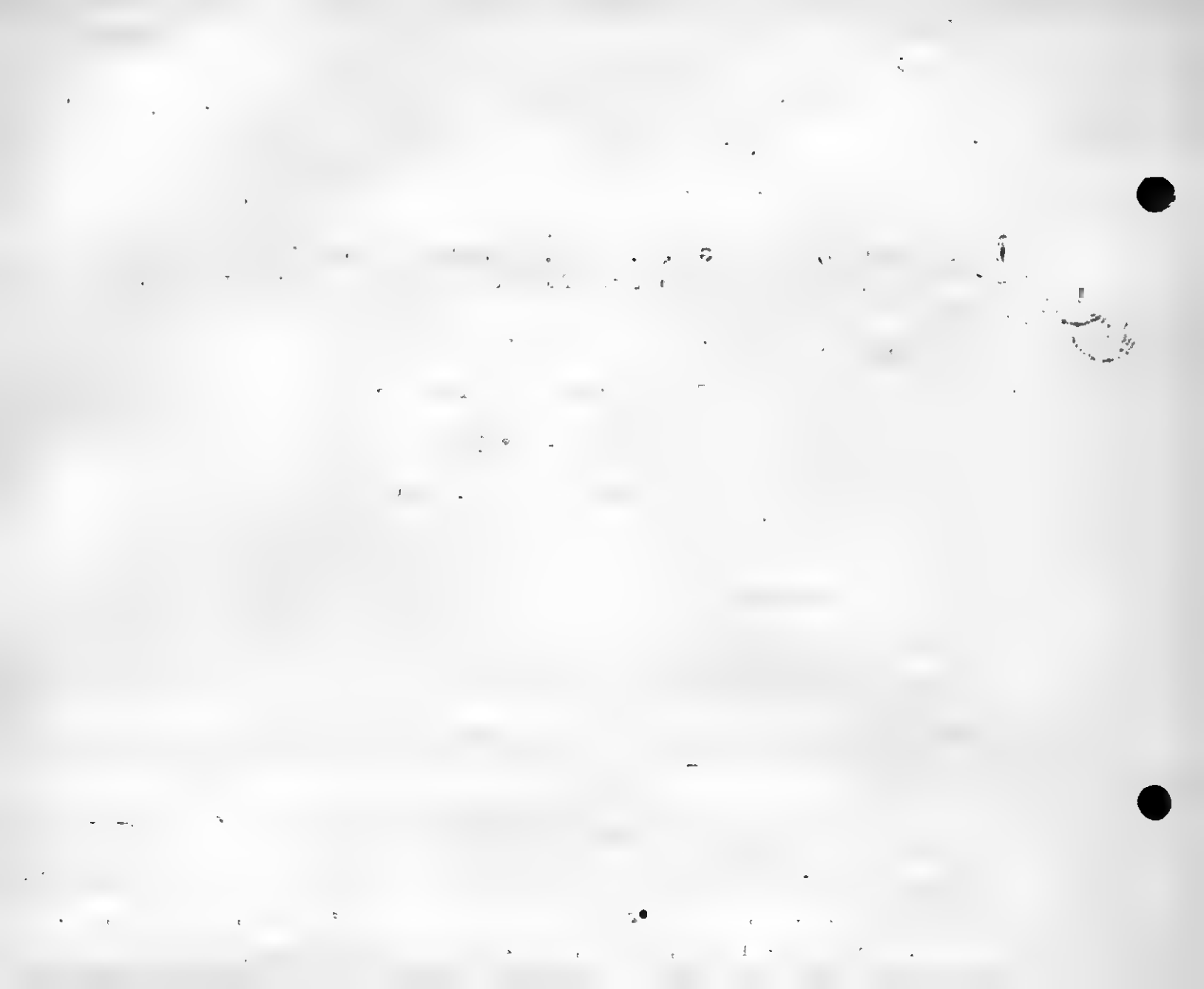
13991

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Lost	2a DATE OF DEATH Month Day Year			2b HOUR P				
NELLE H						10 8 68			10:35				
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
female		CAU		11-3-1889		78RS							
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md							
Frederick Co. Md.		U.S.A.											
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE, MD			GREAT. BALT. MED CEN.			Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER				
			Baltimore		Timonium				225 Chantry Rd.				
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME			First	Middle	Lost		
Champe Mauzey						Katherine Hilliery							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17. INFORMANT			Address				
No			710 09 5900			Hospital Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>10-7</u> , 19 <u>68</u> to <u>10-8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE 								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-8-68	
22d. PHYSICIAN'S NAME (Type) DR. YEH								22e. ADDRESS 6701 N CHARLES ST BALT, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		Oct. 12, 68		Moreland		Baltimore, Baltimore, Md.							
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204						25a. REC'D BY REGISTRAR DATE OCT 10 1968		25b. REGISTRAR'S SIGNATURE 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13992

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14003

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
DOROTHY (DORA)				FLAX	OCTOBER 27, 1968		10 A.M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE		OCTOBER 31, 1907		60 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
BALTIMORE, MD.		U.S.A.				BALTIMORE Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Pikesville		133 SLADE AVENUE		EXECUTIVE		CHILDRENS WEAR		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		BALTIMORE						6600 VINCENT LANE
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
BARNET				WEINSTEIN	ALTA			GERSUK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
NO						MRS. PATRICIA RUDIE, 3204 WOODVALLEY DR. # 8		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>circular fibrillation</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>41 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>416</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 25, 1968</u> to <u>Oct 27, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Oct 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
<u>Leonard Wallenstein</u>		<u>10/28/68</u>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
LEONARD WALLENSTEIN		848 W. 36th STREET						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		10-28-68		KNESSETH ISRAEL ANSHE KOLK		WOLYN, BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				DATE OCT 30 1968		<u>Charles Judge</u>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

138922										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14004									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or Print)					First Middle Last					2a. DATE KNOWN OF DEATH					2b. HOUR														
JOHN JOSEPH					FLINT					Month Day Year					1:00a														
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD					2d. HOUR												
Male		White		6-29-48		20 YRS		MONTHS DAYS		HOURS MIN		Month Day Year					1:00a												
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
MARYLAND					USA										Baltimore					Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
Balto.					Balto. Co. Gen. Hospital					SERVICE STATION					ESSO														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
Md.					BALTO.					Balto.										5926 Prince George Ave.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
JOSEPH G. FLINT					MARIE GAYZARN																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO					17. INFORMANT					ADDRESS														
NO					219-58-0643					JOSEPH G. FLINT					5926 PRINCE GEORGE														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple traumatic injuries																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c) DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>										21b. TIME OF INJURY Month, Day, Year										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
										11:01 PM 10 12 68										Subject driver in auto-fixed object coll.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION street or RFD No City or Town County State									
										Street										Dogwood Rd. past Hollofield Rd. Daniels, Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER										22b. DATE SIGNED									
EXAMINER'S NAME (Type)										ASS STANT MEDICAL EXAMINER										October 12, 1968									
Ronald N. Kornblum, M.D.										DEPUTY MEDICAL EXAMINER										ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, or other disposition										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY									
BURIAL										10-15-68										LORRAINE PARK CEM									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Edward J. Weber										5311 E. MONROE AVE										OCT 14 1968					Charles Judge				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13994

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14005

1. DECEASED-NAME (Type or print) <b>ARTHUR</b>		First <b>LEE</b>		Last <b>FORD</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>18</b> Year <b>68</b>			2b. HOUR <b>11:30A</b>		
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>10/3/15</b>		6. AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VEI. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>ELEVATOR OPERATOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE OF MARYLAND</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1348 N. Stricker Street</b>			
14. FATHER'S NAME First <b>LEWIS</b>		Middle <b>FORD</b>		Last <b>FORD</b>		15. MOTHER'S MAIDEN NAME First <b>INDIA</b>		Middle <b>HAWKES</b>		Last <b>HAWKES</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ARTERIOCLEROSIS</b> (b) <b>NEPHROSCLEROSIS</b> (c) <b>ARTERIOCLEROSIS</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>9/19/68</b> , 19____, to <b>10/18/68</b> , 19____, that <b>(I)</b> (we) last saw the deceased alive on <b>10/18/68</b> , 19____, and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Neilon Neilson, M.D.</b>		22c. DATE SIGNED <b>10/18/68</b>		22d. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>V.R. Bailey</b>		ADDRESS <b>Kelson Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>					



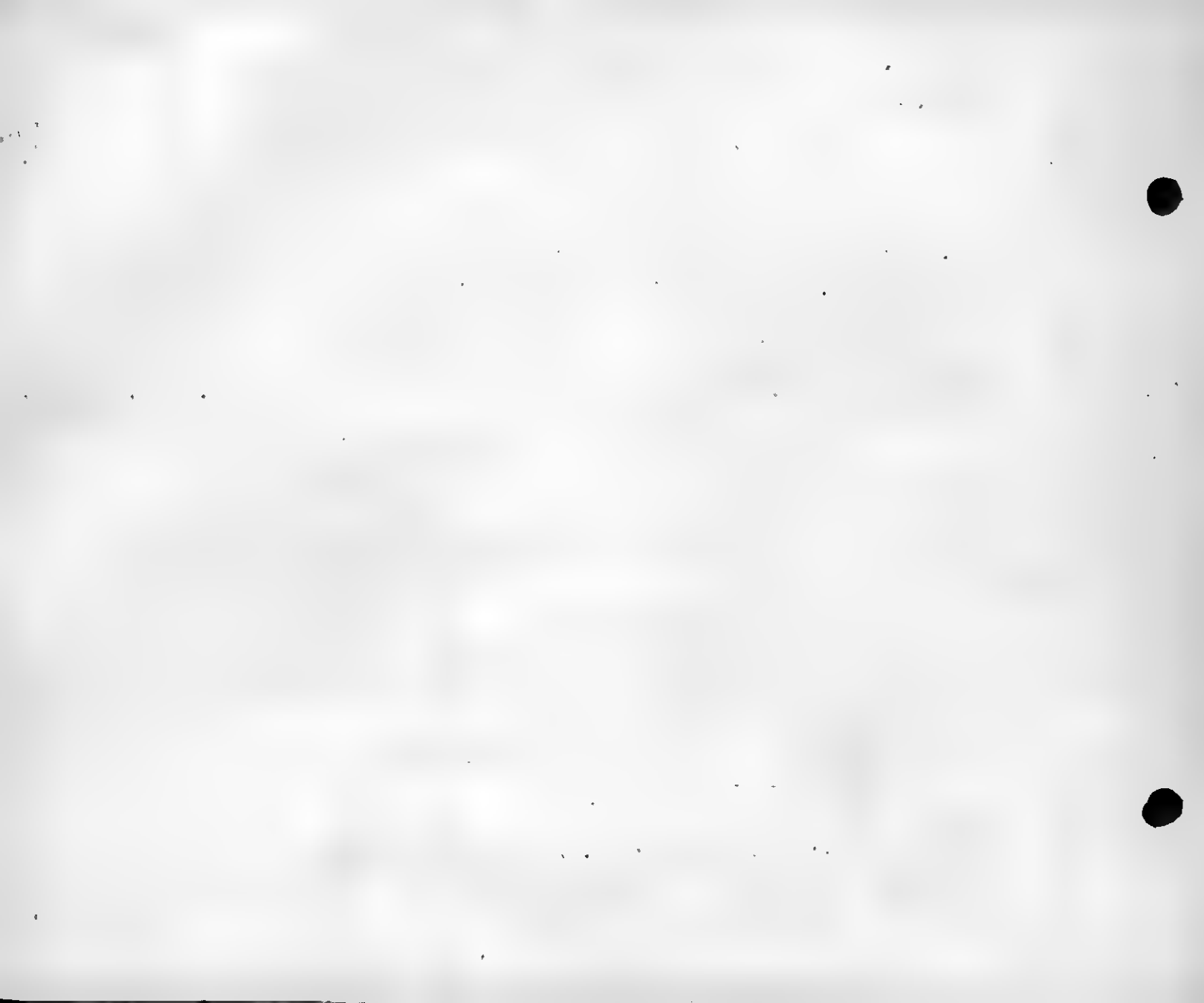
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14006	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type name)		First ALVIN		Middle RAYMOND		Last FUNK		2a DATE KNOWN OF DEATH Month Day Year		2b HOUR M	
13995								19		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
Male		White		1/3/19 1921		49.7 YRS					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH		2c DATE PRONOUNCED DEAD Month Day Year	
Maryland				USA				BALTIMORE		October 19, 1968	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Ellicott City				6 Oella Avenue				Shipping Clerk		Donut Corp	
13a USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY, M.T.S?		13e STREET AND NUMBER	
Md.				Baltimore		Ellicott City		YES <input type="checkbox"/> NO <input type="checkbox"/>		6 Oella Avenue	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
Charles W. Funk				Gertrude Piffer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
yes				N.W. 2		219 03 4502 Garland Funk 3602 Lilac Ave. Balto. 21227, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 411											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF DEATH Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springgate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED October 19, 1968			
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL, etc.		23b. DATE		23c. NAME OF CEMETERY OR CRIMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		10/23/68		Good Shepherd		Ellicott City		Howard		Md.	
24. FUNERAL DIRECTOR Higinbotham Slack				ADDRESS Ellicott City, Md,				25a. RECEIVED BY REGISTRAR DATE OCT 23 1968		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 2 and 3, and 4, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

16  
13996

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14007

1. DECEASED-NAME (Type or print) First Middle Last SAMUEL GARBIS			2a. DATE OF DEATH Month Day Year OCTOBER 7, 1968		2b. HOUR 11:45 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH SEPTEMBER 15, 1909		6. AGE (In years last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH GARRISON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FOXLEIGH NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) UPHOLSTERY	12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6805 GIST AVENUE	
14. FATHER'S NAME First Middle Last ISRAEL GARBIS	15. MOTHER'S MAIDEN NAME First Middle Last ANNA BOTWINCK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16b. SOCIAL SECURITY NO W.O. II ARMY 217-12-8372	17. INFORMANT Address MRS. ADELE GARBIS, 6805 GIST AVE. #21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor (glioblastoma)</u> 191X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 6 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1962 to Oct 7, 1968, that (I) (we) last saw the deceased alive on Oct 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Irvin Sauber MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) IRVIN SAUBER		22e. ADDRESS 6905 PARK HEIGHTS AVENUE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-10-68	23c. NAME OF CEMETERY OR CREMATORY MOSES MONTIFILORE	23d. LOCAT ON (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR DATE OCT 14 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE  
HEALTH DEPT.

13997

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14008

1 DECEASED NAME (Type or Print) <b>KENNETH L. GARMAN</b>		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <b>OCT 7 1968</b>		2b HOUR M	
3 SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>3/22/19</b>		6 AGE (In years last birthday) <b>49</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month <b>OCT</b> Day <b>7</b> Year <b>1968</b>	
7a BIRTHPLACE (State or foreign country) <b>PA.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO.</b>					
10 CITY OR TOWN OF DEATH <b>ESSEX</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1629 EASTERN AVE</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY <b>MARTIN CO</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE <b>MD.</b>		13b COUNTY <b>BALTO.</b>		13c CITY OR TOWN <b>ESSEX</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1629 EASTERN AVE</b>			
14. FATHER'S NAME First Middle Last <b>LEROY GARMAN</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGIE BEVENS</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		(If yes give war or dates of service) <b>WW II</b>		16b SOCIAL SECURITY NO <b>173-05-902</b>		17 INFORMANT <b>KATHRYN GARMAN</b>		ADDRESS <b>ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109 Ocute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Essignous Obesity</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>W. C. Patterson</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/7/68</b>	
EXAMINER'S NAME (Type) <b>W. C. PATTERSON</b>		ADDRESS		ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b DATE <b>10/9/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>GOUGLERSVILLE</b>		23d LOCATION (City or Town) <b>GOUGLERSVILLE</b>		(County) <b>PA</b>		(State)	
24. FUNERAL DIRECTOR <b>J. E. CONNELLY SONS</b>				ADDRESS <b>300 MACE</b>		25a REC'D BY REGISTRAR DATE <b>OCT 9 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





13999

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (First, Middle, Last) <b>MAGGIE GARRETT</b>			2a. DATE OF DEATH <b>OCT</b> Month <b>9</b> Day <b>1968</b>			2b. HOUR <b>2:55 A.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12/10/77</b>		6. AGE (In years lost birthday) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>House in the Pines</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5504 Carville Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Bruffett Taylor</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Helen Lane</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>213-48-6492</b>		17. INFORMANT <b>Helen Kelly</b>		Address <b>5504 Carville Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>ASCUD-</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>Oct 9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct 7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Earl Pass MD</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10-9-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>EARL PASS</b>		22e. ADDRESS <b>4001 WILKENS Ave</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Ambrose Inc 1328 Sulphur Sq. Rd.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DATE OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 148  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> <span>13999</span> <span>CERTIFICATE OF DEATH</span> <span>14010</span> </div>										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Bernard Horace GASS						Month 10 Day 23 Year 68			5:50 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7. IF UNDER 1 YEAR		
Male		White		8/23/29		39 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Owings Mills			Rosewood State Hospital			Dependent			none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			St. Mary			Abell		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
John Edward GASS			Lola Lee HAYDEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address				
no			none			Rosewood Records, Owings Mills, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Inanition and Dyscrasia</u>										
577.8 DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Post-sclerotic Cirrhosis of the Liver</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
5810 <u>Mongolism</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (X) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>65</u> , to <u>10/23</u> , 19 <u>68</u> , that (X) (we) lost the deceased alive on <u>10/23</u> , 19 <u>68</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<u>Harry G. Butler, M.D.</u>								10/23/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Harry G. Butler, M.D.				Rosewood St. Hosp., Owings Mills, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10/26/1968		Sacred Heart		Brushwood, St. Marys Md.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>W. Clarke Mattingley, Leonardtown, Md.</u>				DATE		OCT 28 1968		<u>Charles Judge</u>		



14000

## CERTIFICATE OF DEATH

14011

1. DECEASED NAME (Type or print) <b>ELENORA ELIZABETH GEELHAAR</b>			2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>2:40 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>FEB. 4, 1903</b>		6. AGE (in years last birthday) <b>65</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE 4</b> Md.	
10. CITY OR TOWN OF DEATH <b>TOWSON 4</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>9629 10th Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Albert Merson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Family records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolism</b> <b>450X</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>450X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>to</del> (this hospital) attended the deceased from <b>OCT. 10</b> , 19 <b>68</b> , to <b>OCT. 19</b> , 19 <b>68</b> , that <del>to</del> (we) lost saw the deceased alive on <b>OCT. 19</b> , 19 <b>68</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>to</del> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Christina Feliciano, M.D.</i> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>OCT. 19, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Christina Feliciano, M.D.</b>				22e. ADDRESS <b>7620 YORK ROAD, TOWSON 4, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto Co Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>C.F. EVANS &amp; SON 8802 Harford road</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14001

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14012

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR Min.					
Jeannelle Bloss					Oct 27 68		4:55 A.M.					
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
F	W		FEB-10-93		73 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				Md.		
Maryland		U.S.A.				Baltimore						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY						
Randallstown, Md.		Balto. Co. General Hosp.		Housewife								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Maryland		Balto. Co.		Randallstown				3806 Brown Hill Rd.				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
?					?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address				
NO				219-30-4625		Mr. Jerome J. Gloss		11900 Reisterstown Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4211</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>10-24</u> , 19 <u>68</u> , to <u>10-27</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>10-27</u> , 19 <u>68</u> , and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.												
22b. SIGNATURE <u>Dr. Loring Byers</u>					22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED <u>10-27-68</u>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS							
23a. BURIAL, CREMATION Burial		23b. DATE Oct. 29, 68		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		23d. LOCATION (City or Town)		(County)		(State)		
						Finksburg		Carroll		Md.		
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown.					25a. REC'D BY REGISTRAR DATE <u>OCT 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14002

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14013

1. DECEASED NAME (Type or print) First Fannie Middle Lee Last Goodloe			2a. DATE OF DEATH Month October 3, Day 1968 Year		2b. HOUR 9:00 p.m.
3 SEX female	4 RACE white	5. DATE OF BIRTH Sept. 24, 1877		6 AGE (In years last birthday) 90 9/1 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Penn.	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Catonsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER R.F.D. #1	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 213-50-5974		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4124					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from May 3, 1968, to Oct. 3, 1968, that (X) (we) lost saw the deceased alive on Oct. 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Diomidis L. Pirovolidis		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-4-68	
22d. PHYSICIAN'S NAME (Type) Diomidis L. Pirovolidis, M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/8/1968	23c. NAME OF CEMETERY OR CREMATORY Lincoln		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Ernest Jarvis Co. Inc.		ADDRESS 1432 N. W. St.		25a. REC'D BY REGISTRAR DATE OCT 7 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

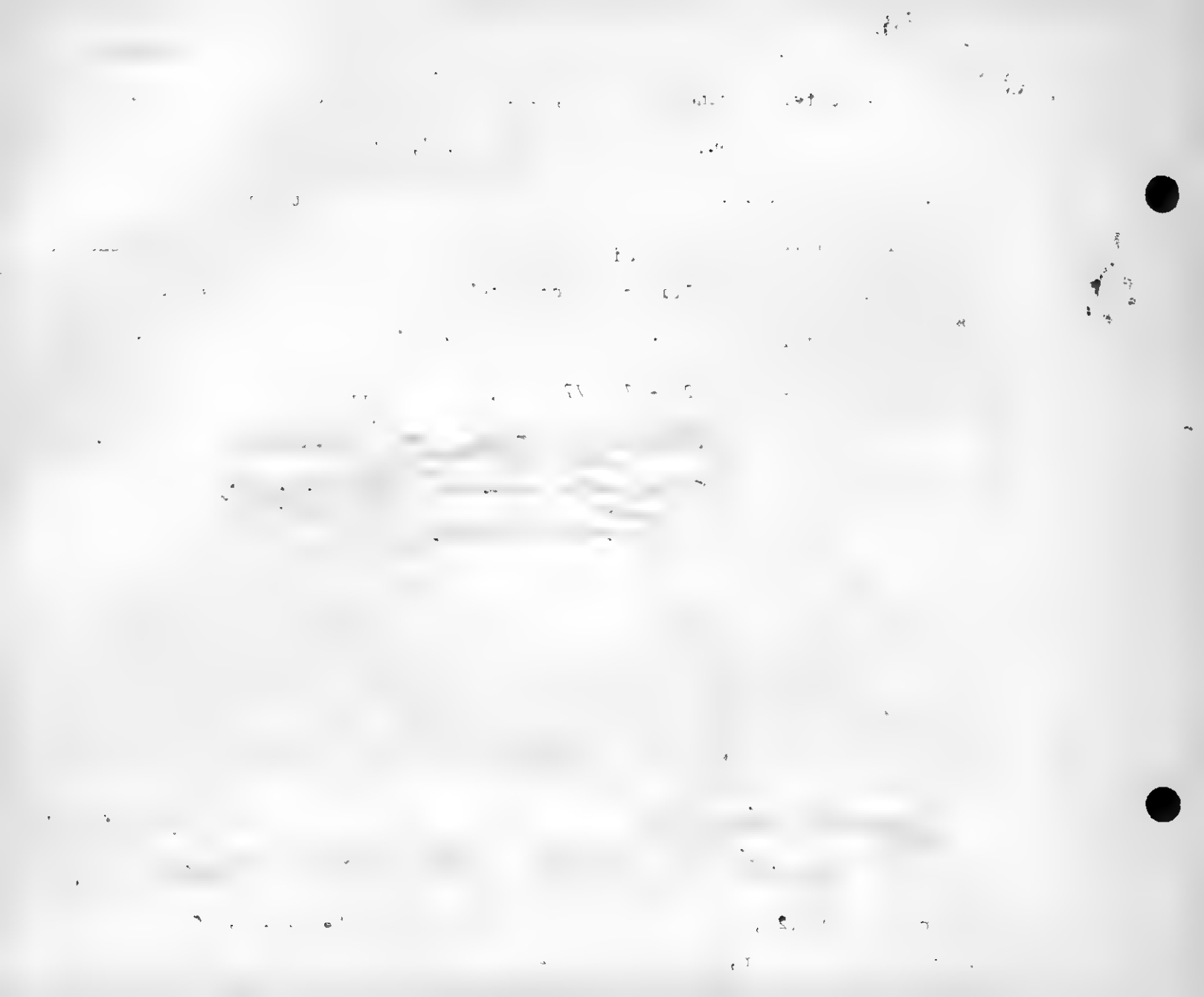
14003

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14014

1. DECEASED NAME (Type or print) Walter Franklin Gover, Sr.			2a. DATE OF DEATH Oct. Month 18 Day 1968		2b. HOUR
3. SEX Male	4. RACE Cay.	5. DATE OF BIRTH Sept. 7, 1913		6. AGE (In years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Cockeysville (Texas)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Railroad Ave		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Labor	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIM TSY YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Railroad Ave.
14. FATHER'S NAME First Middle Last Walter Gover		15. MOTHER'S MAIDEN NAME First Middle Last Virgie Ford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes Mar 41-Aug 44		16b. SOCIAL SECURITY NO 213-07-7077	17. INFORMANT Address Margaret Govern, Same as # 13		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma of brain</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>metastasis to lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cachexia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		<input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-18-68</u> , to <u>10-18-68</u> , that (I) (we) last saw the deceased alive on <u>10-18-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James B. Saffell</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-19-68	
22d. PHYSICIAN'S NAME (Type) James B. Saffell		22e. ADDRESS Reisterstown, Md			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 21, 1968	23c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Rd. 21204		25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



14004

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

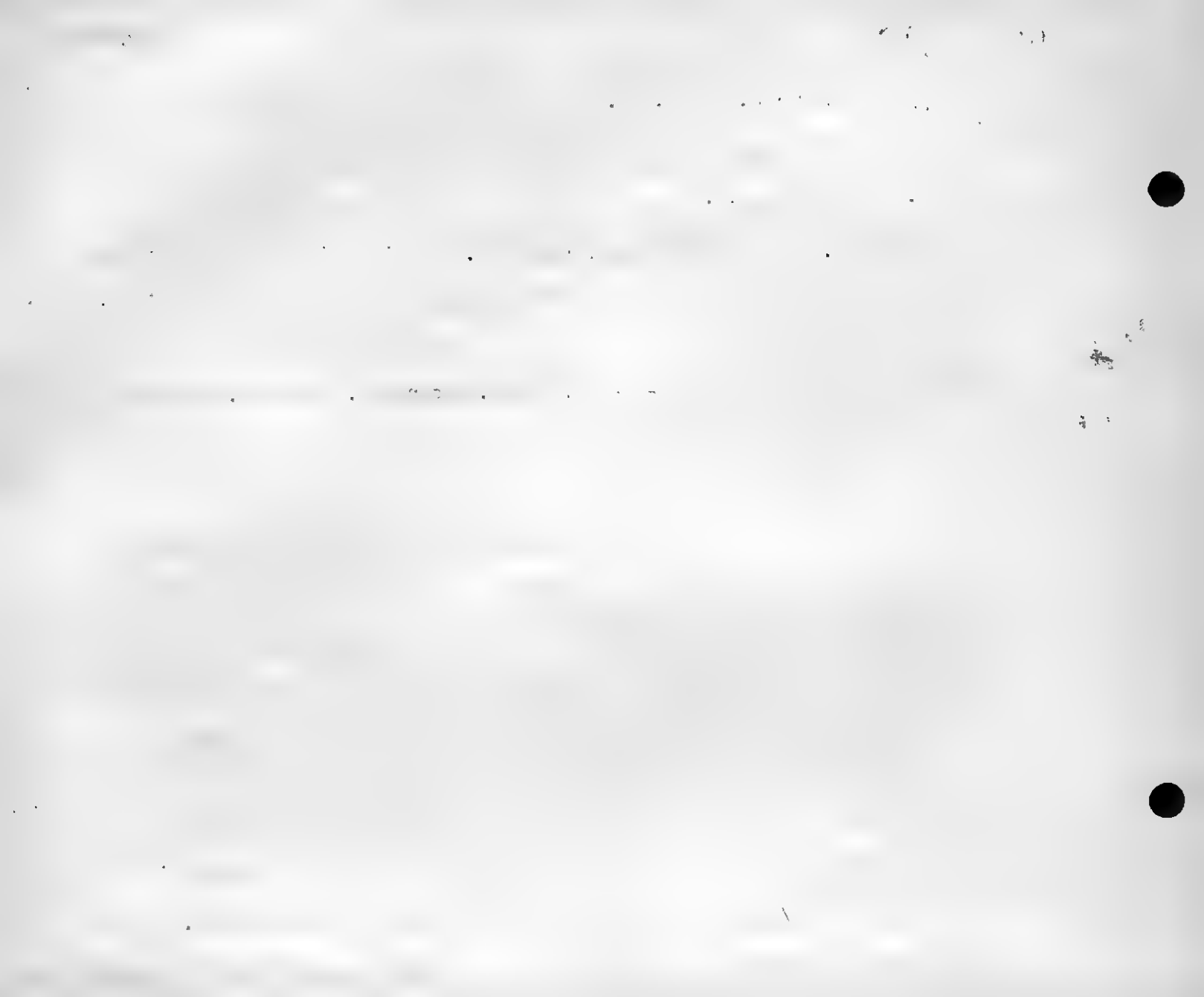
14015

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year				2b HOUR							
George J. Grace, Sr.								10/24 1968				10 AM							
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year				2d HOUR					
Male	White	2/22/14		54 YRS						10 24 1968				12 AM					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH								Md					
Md.		U.S.A.				Baltimore													
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY							
Lansdown, Md.				2222 Hammonds Ferry Rd.				Painter				Painting							
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET AND NUMBER			
Md.								Baltimore				2222 Hammonds Ferry Road.							
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME															
William Grace				Katherine Eichelman															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17 INFORMANT ADDRESS											
No				215-16-2667				Mrs. George J. Grace, Sr. 2222 Hammonds Ferry Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>																			
5719 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
(b) <u>Cirrhosis Liver</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
<u>Aspirin</u> <u>Seizure Episodes unknown Etio.</u>																			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
				9															
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>James N. Frederick</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <u>10/24/68</u>											
EXAMINER'S NAME (Type) <u>James N. Frederick</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<u>1311 Francis Ave</u>											
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>Baltimore, Md.</u>											
				ADDRESS (Street, city, town, or county)															
23b BURIAL, CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Burial				10/28/68				New Cathedral cemetery				Baltimore, Md.							
24 FUNERAL DIRECTOR				ADDRESS				25a RECD BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
Witzke, 4101 Edmondson Ave., 21229								DATE <u>OCT 28 1968</u>				<u>J. Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

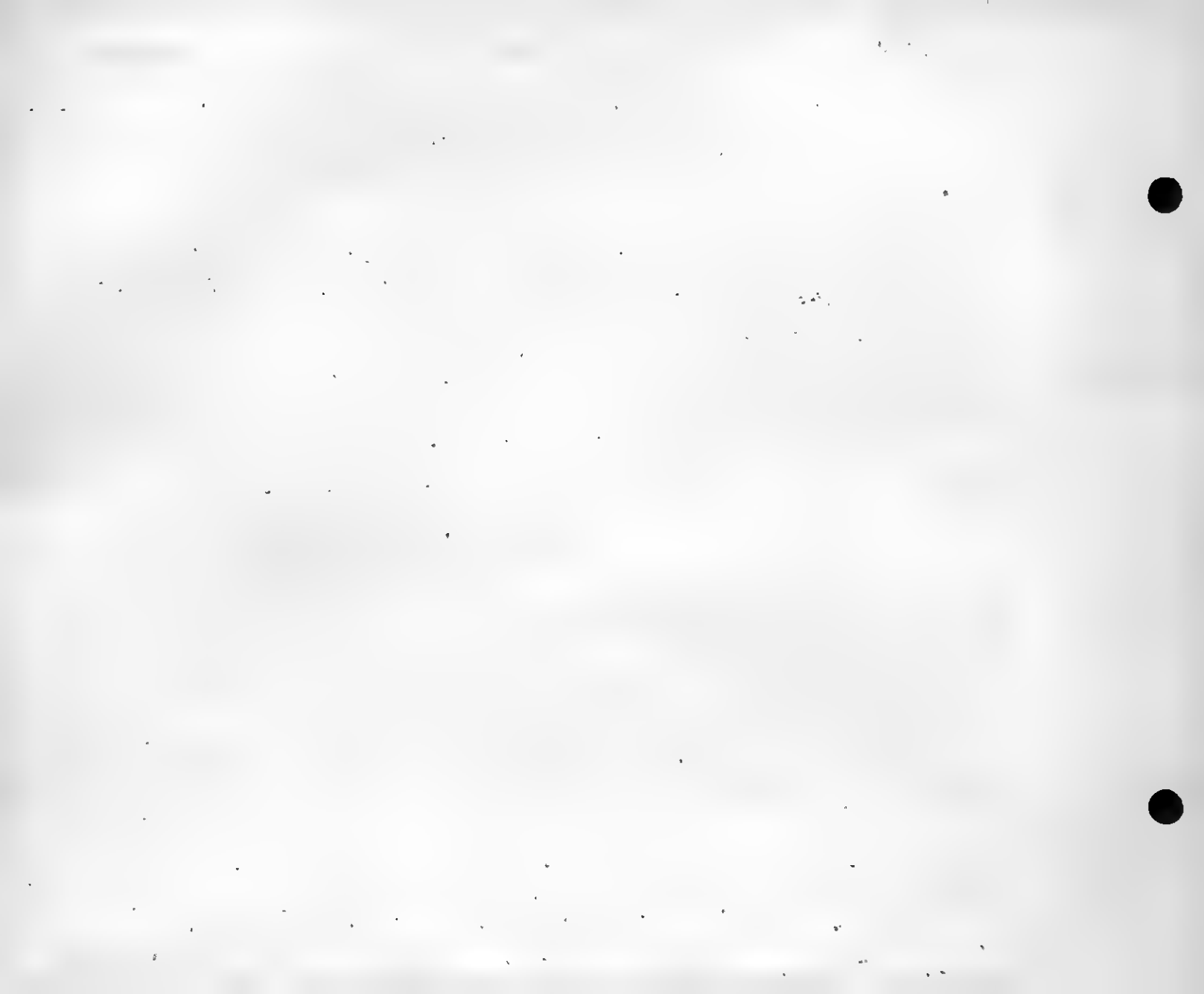
14005

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14016

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
George		Wilson	Groom		10 Month 3 Day 68 Year		11:45 P		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male	Caucasian		7/4/97		71 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Greater Balto. Med. Center		SECRETARY-RET.		LODGE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		ROGERS FORGE				249 ROGERS FORGE RD.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
FRED A. GROOM		MARGARET WILSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or date of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
YES		217-07-3302		Family Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Hypertensive arteriosclerotic cardiovascular</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>disease with coronary atherosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>68</u> , to <u>10/3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Charles C. Brown, M.D.		10/4/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Charles C. Brown, M.D.		6701 N. Charles Street							
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		OCT. 7, 1968		BALTIMORE NATL. CEM.		BALTIMORE, MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John Burns Sons & Son		OCT 7 1968		Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

Item 6 Film G407 12/3/68 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 <b>CERTIFICATE OF DEATH</b>											
1. DECEASED-NAME (Type or print) First Middle Last August Gross						2a. DATE OF DEATH Month Day Year October 27 1968			2b. HOUR MIN 12:30 P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH November 20, 1882		6. AGE (In years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rosewood		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) dependent		12b. KIND OF BUSINESS OR INDUSTRY none					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1125 Franklin Street			
14. FATHER'S NAME First Middle Last August Gross				15. MOTHER'S MAIDEN NAME First Middle Last Amelia Poehnert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 215-50-6890		17. INFORMANT Patient's chart				Address Rosewood			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sudden Coronary Thrombosis Right Left Sided</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. YRS 0	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (this hospital) attended the deceased from 8/31/67, to 10/27, 1968, that (I) (we) last saw the deceased alive on 10/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.											
22b. SIGNATURE <i>Richard A. Jones M.D.</i>				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/28/68			
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.				22e. ADDRESS Rosewood State Hospital, Owings Mills, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/1968		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR <i>Santa Linnell</i>		ADDRESS 5209 York Rd		25a. RECEIVED BY REGISTRAR DATE OCT 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14007

14018

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>C. Franklin Grubb</b>			2a DATE OF DEATH <b>Oct. 18</b> Day <b>18</b> Year <b>68</b>			2b. HOUR <b>1:30 A.M.</b>			
3. SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>Feb. 6, 1891</b>		6 AGE (in years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Balto.</b> Md.			
10. CITY OR TOWN OF DEATH <b>White Hall</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Graystone Rd.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Farm-</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>md.</b>		13b COUNTY <b>Balto.</b>		13c CITY OR TOWN <b>White Hall</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Graystone Rd.</b>	
14. FATHER'S NAME First <b>Albert</b> Middle <b>Grubb</b> Last <b>Grubb</b>			15 MOTHER'S MAIDEN NAME First <b>Rebecca</b> Middle <b>Rakes</b> Last <b>Rakes</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <b>214-34-2858</b>		17 INFORMANT <b>Mrs. Lona J. Grubb, White Hall, Md.</b> Address <b>White Hall, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>G. S. C. V. Disease</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Peptic ulcer</b>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>10/17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/17</b> 19 <b>68</b> , and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>C. M. France</b>		22c. DATE SIGNED <b>10/19/68</b>		22d. PHYSICIAN'S NAME (Type) <b>R. M. FRANCE</b>		22e. ADDRESS <b>PARKTON, Md.</b>			
23a B. R. A. L. CREMATION, REMOVAL (Specify)		23b. DATE <b>10/20/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Wiseburg Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>White Hall, Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>James L. Hartenstein, New Freedom, Pa.</b>		25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14003

14019

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Lillian</i>		2. First Middle Last <i>Hampshire</i>		2a. DATE OF DEATH Month <i>10</i> Day <i>17</i> Year <i>1968</i>			2b. HOUR <i>5:45</i> M		
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>11-14-1885</i>		6. AGE (In years last birthday) <i>82</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore General Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>7-320 Maple Rd.</i>	
14. FATHER'S NAME First Middle Last <i>John Langfield Pharo</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Lucinda</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>3388</i>		17. INFORMANT Address <i>John D. Hampshire 611 Coventry Rd. #21204</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>43% of</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>7 years</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>3388 None</i>									
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>April, 1960</i> to <i>Oct. 17, 1968</i> , that (I) (we) lost saw the deceased alive on <i>Oct. 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.									
22b. SIGNATURE <i>L. Myrton Gaines Jr.</i>		DEGREE <i>Dr. L. Myrton Gaines, Jr.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Oct. 17, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. L. Myrton Gaines, Jr.</i>		22e. ADDRESS <i>7800 York Road Balto., Md. 21204</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/19/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION (City or Town) (County) (State) <i>Balto. County, Md.</i>			
24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld</i>		ADDRESS <i>Home 6500 York Rd. Balto., Md. 21212</i>		25a. REC'D BY REG. STRAR <i>OCT 22 1968</i>		25b. REG. STRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undertaker, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14009

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14020

1. DECEASED-NAME (Type or print) <i>Margaret M. Hardt</i>			2a. DATE OF DEATH Month <i>Oct.</i> Day <i>31</i> Year <i>1968</i>		2b. HOUR <i>9:15 PM</i>
3 SEX <i>Female</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>Dec. 19, 1884</i>		6. AGE (In years last birthday) <i>83</i> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore Co.</i> Md		
10. CITY OR TOWN OF DEATH <i>Catonisville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INS. DE. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>1217 Camberwell Rd.</i>	
14. FATHER'S NAME First <i>Thomas J.</i> Middle <i>Rich</i> Last <i>Hardt</i>	15. MOTHER'S MAIDEN NAME First <i>Mary Katherine</i> Middle <i>Plertney</i> Last <i>Hardt</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		
16b. SOCIAL SECURITY NO. <i>215-03-5502</i>		17. INFORMANT Address <i>J Richard Hardt Balt Md 21228</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>41 CORONARY INSUFFICIENCY</i> <i>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</i> <i>PACEMAKER.</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>RENAL INSUFFICIENCY - CHRONIC GLOMERULOPATHY</i> <i>NEPHRITIS, 29 ANEMIA.</i> <i>TRACTURE OF RIGHT HIP, URINARY TRACT INFECTION.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>+201</i>					
19a. DATE OF OPERATION <i>7-28-1968</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>None</i>	21b. TIME OF INJURY HOUR A.M. Month Day Year <i>7-28-1968</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell at home</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>	21f. LOCATION Street or R.F.D. No <i>4511</i> City or Town <i>Manor</i> County <i>Deane</i> State <i>Rd. Cath. City Md.</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/21</i> , 1968, to <i>10/31</i> , 1968, that (I) (we) last saw the deceased alive on <i>10/30</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. Kasa-Tis, M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>10/31/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>E. KASA-TIS, M.D.</i>		22e. ADDRESS <i>1801 FREDERICK RD BALTIMORE MD 21228</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>11/4/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md</i>		
24. FUNERAL DIRECTOR <i>Edm Currie</i>	ADDRESS <i>Louis West</i>	25a. REC'D BY REGISTRAR <i>not here</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 515  
30M REV. 1/68

14010

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14021

1. DECEASED-NAME (Type or print) <b>MARGARET W HARDY</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR M <b></b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOV. 1 1883</b>		6. AGE (In years last birthday) <b>84 YRS</b>		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CATONSVILLE Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE MD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CATON RIDGE N. HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b></b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2510 Burridge Rd</b>	
14. FATHER'S NAME First <b>JOHN</b> Middle <b></b> Last <b>WALTZ</b>			15. MOTHER'S MAIDEN NAME First <b>Minna</b> Middle <b>Solvech</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b></b>		17. INFORMANT Name <b>William A. Hardy</b> Address <b></b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>years</b> <b>years</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)) <b></b>										
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b></b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)			21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b></b>			21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>6-13-1968</b> to <b>10-10-1968</b> , that (I) (we) last saw the deceased alive on <b>10-10-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Cesar Valle Caverio M.D.</b> DEGREE <b></b>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10-10-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>CEGAR VALLE CAVERO</b>						22e. ADDRESS <b>8629 Liberty Rd.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10/14/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>						25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-100, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 111-106 10/29/68 <b>14013</b>										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14022																																																																																				
1 DECEASED NAME (Type or Print) <b>GLEN N STANLEY</b>															2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>10-20 1968</b>															2b. HOUR <b>M</b>																																																																										
3 SEX <b>Male</b>															4. RACE <b>Negro</b>															5. DATE OF BIRTH <b>9-23-51</b>															6 AGE (In years last birthday) <b>17</b> YRS															IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.															2c. DATE PRONOUNCED DEAD Month Day Year <b>October 20, 1968</b>															2d. HOUR <b>8:30 A.M.</b>														
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>															7b. CITIZEN OF WHAT COUNTRY?															8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>															9. COUNTY OF DEATH <b>BALTIMORE</b>															Mo.																																												
10. CITY OR TOWN OF DEATH <b>TOWSON</b>															11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Expressway Ruxton Road Overpass</b>															12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)															12b. KIND OF BUSINESS OR INDUSTRY																																																											
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>															13b. COUNTY <b>Baltimore</b>															13c. CITY OR TOWN <b>Baltimore</b>															3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>															13e. STREET AND NUMBER <b>1615 E. 31st. Street</b>																																												
14. FATHER'S NAME <b>Stanley Harris</b>															15. MOTHER'S MAIDEN NAME <b>Sadie Mc Knight</b>															16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)															16b. SOCIAL SECURITY NO															17. INFORMANT <b>Sadie Harris</b>															ADDRESS <b>1615 E. 31st St.</b>																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple severe injuries</b> <b>815.1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>812.4</b>																																																																																																								
19a. DATE OF OPERATION															19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																																										
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH															21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>7:40 AM 10-20 1968</b>															21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Passenger in auto-fixed object collision</b>																																																																										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK															21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Expressway</b>															21f. LOCATION Street or R.F.D. No City or Town County State <b>Ruxton Road Overpass Baltimore Md.</b>																																																																										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																																																								
ACTUAL SIGNATURE <b>Charles S. Springate</b>															M.D.															CHIEF MEDICAL EXAMINER <input type="checkbox"/>															ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>															DEPUTY MEDICAL EXAMINER <input type="checkbox"/>															22b. DATE SIGNED <b>October 20, 1968</b>																													
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>																														ADDRESS (Street, city, town, or county)																																																																										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>															23b. DATE <b>10-24-68</b>															23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>															23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>																																																											
24. FUNERAL DIRECTOR <b>Wilmington Phillips</b>															ADDRESS <b>1727 N. Mount St.</b>															25a. DATE OF REGISTRATION <b>OCT 24 1968</b>															25b. REGISTRAR'S SIGNATURE <b>James Judge</b>																																																											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14012										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14023									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) <b>MAAMAH V. HARRISON</b>										2a. DATE OF DEATH <b>OCT. 17 1968</b>										2b. HOUR <b>6:00 A.M.</b>									
3. SEX <b>F</b>					4. RACE <b>W</b>					5. DATE OF BIRTH <b>JULY 19, 1899</b>					6. AGE (In years last birthday) <b>69</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>BALTIMORE</b> Md														
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>224 MEDWICK GARTH</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEKEEPER</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>					13b. COUNTY <b>BALTO.</b>					13c. CITY OR TOWN <b>CATONSVILLE</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>224 MEDWICK GARTH #28</b>									
14. FATHER'S NAME First Middle Last <b>EDWARD J. HARRISON</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>IDA V. DAVIS</b>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <b></b>					17. INFORMANT <b>Joseph M. Harrison - 235 Broken Rd.</b> Address <b></b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>412 Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>atherosclerosis CVD</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>10 yrs.</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b></b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19 1968</b> , to <b>Oct 17, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 19 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>J. Charles Judge M.D.</b>										22c. DATE SIGNED <b>10/18/68</b>					22d. PHYSICIAN'S NAME (Type) <b>J. Charles Judge</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>10-19-68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cem.</b>					23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>														
24. FUNERAL DIRECTOR <b>Tracy-Corran B.F.H. Catonsville, Md.</b>										25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
1. DECEASED-NAME (Type or print)		First <b>WILLIAM</b>		Middle <b>MC CLELAN</b>		Last <b>HARTMAN</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>31</b> Year <b>68</b>		2b. HOUR <b>2:10 PM</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>8/21/15</b>		6. AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS <b>53</b> DAYS <b>53</b>		IF UNDER 24 HRS. HOURS <b>53</b> MIN <b>53</b>
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY</b> Md.				
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>MEAT PACKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MEAT PACKING</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3243 ELLIOTT STREET</b>		
14. FATHER'S NAME First <b>BERNARD</b> Middle <b>HARTMAN</b> Last <b>HOGGE</b>		15. MOTHER'S MAIDEN NAME First <b>MARGARET</b> Middle <b>HOGGE</b> Last <b>HOGGE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>YES</b> (If yes give year or dates of service) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>217 09 2967</b>		17. INFORMANT Address <b>Clin. Rec. VAH, Fort Howard, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA RIGHT LUNG</b> <b>10/21</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>10/21</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CHRONIC MALNUTRITION</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b>										
19a. DATE OF OPERATION <b>9/25/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SCALENE LYMPH NODE BIOPSY</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) <input type="checkbox"/> OFFICE BUILDING, ETC <input type="checkbox"/>		21f. LOCATION Street or R.F.D. No. <b>4</b> City or Town <b>BALTIMORE</b> County <b>BALTIMORE</b> State <b>MARYLAND</b>		22a. I certify that (he) (this hospital) attended the deceased from <b>Oct. 4</b> , 19 <b>68</b> , to <b>Oct. 31</b> , 19 <b>68</b> , that (he) (we) lost saw the deceased alive on <b>Oct. 31</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) <b>not</b> view the body after death.				
22b. SIGNATURE <b>John C. Dumlery, Jr. M.D.</b>		22c. DATE SIGNED <b>10/31/68</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN C. DUMLER, JR. M.D.</b>		22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>		22f. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-4-68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>Charles S. Zeiler</b> <b>Charles Zeiler Funeral Home</b>		
25a. REC'D BY REGISTRAR DATE <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>						





CERTIFICATE OF DEATH

14025

14014

Item #23, Film G406 11/22/68 km

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c LENGTH OF STAY IN 1b <b>APPROX 2 1/2 MO</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>STELLA MARIS HOSPICE</b>		d. STREET ADDRESS <b>BALTIMORE AVE 4227 Frederick Avenue</b>	
3 NAME OF DECEASED (Type or print) <b>FLORENCE E. HASELHERST</b>		4. DATE OF DEATH <b>Oct. 10 1968</b>	
5 SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1876 3-17-1879</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (County & State or foreign country) <b>BALTIMORE, MD</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOSEPH K. KAISER</b>		14. MOTHER'S MAIDEN NAME <b>HOOKE</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16 SOCIAL SECURITY NO. <b>219-48-8674</b>	
17 INFORMANT <b>STELLA MARIS HOSPICE INC. TOWSON, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4129 Multiple CVA's -</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>ASCVD -</b>			INTERVAL BETWEEN ONSET, AND DEATH <b>3 wks -</b> <b>4 yrs</b> <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4221</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 26</b> , 19 <b>68</b> , to <b>OCT. 10</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>OCT. 9</b> , 19 <b>68</b> , and that death occurred at <b>5:15 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>E. Lee Robbins</b>		22b. DATE SIGNED <b>10/10/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. Lee Robbins, M.D.</b>		22d. ADDRESS <b>Courtyard Apts. Towson, Md. Balto.Co.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>OCT. 12 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHARAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD.</b>
24. FUNERAL DIRECTOR <b>WALTERS FUN'L HOME PRATT+STRICKER STS</b>		25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14015

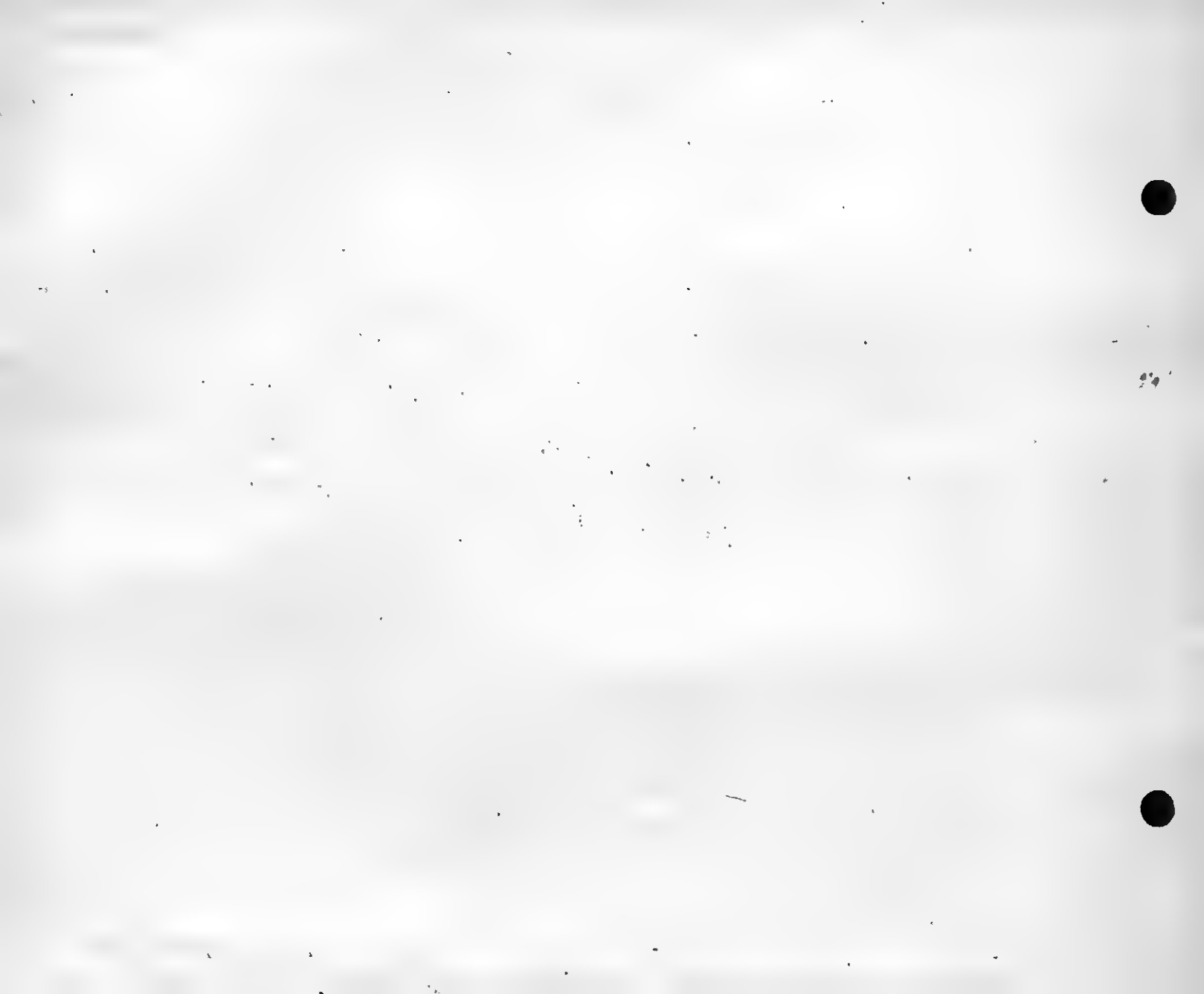
14026

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Ella</b>			First <b>D.</b>			Middle <b>Hauck</b>			Last			2a. DATE OF DEATH 10 Month 30 Day 1968			2b. HOUR 7:30 AM		
3. SEX <b>F</b>			4. RACE <b>W</b>			5. DATE OF BIRTH 7-16-1884			6. AGE (In years last birthday) 84 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>East Bend, N.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.								
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dulaney Valley Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Registered Nurse</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>5100 N. Charles Street</b>					
14. FATHER'S NAME <b>John</b>			First <b>Willis</b>			Middle <b>Davis</b>			15. MOTHER'S MAIDEN NAME <b>Henrietta</b>			First <b>Lynch</b>			Middle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>118-18-6914</b>			17. INFORMANT <b>Mrs. Alfred M. Durand</b> Address <b>RD4 Wyalusing, Pa.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute heart failure. Acute</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal shut down. Arteriosclerotic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Degenerative C.V. Disease</b> Months. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>422</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1952</b> to <b>30 Oct. 1968</b> , that (I) (we) last saw the deceased alive on <b>30 Oct. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Joseph E. Muse, Jr.</b>			22c. DATE SIGNED <b>10/31/68</b>			22d. PHYSICIAN'S NAME (Type) <b>Dr. Joseph E. Muse, Jr.</b>			22e. ADDRESS <b>2725 N. Charles Street</b>								
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>11-1-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>			23d. LOCATION (City or Town) <b>Baltimore,</b>			(County)			(State) <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b>			ADDRESS <b>4905 York Road Balto., Md.</b>			25a. REC'D. BY REGISTRAR <b>NOV 1 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

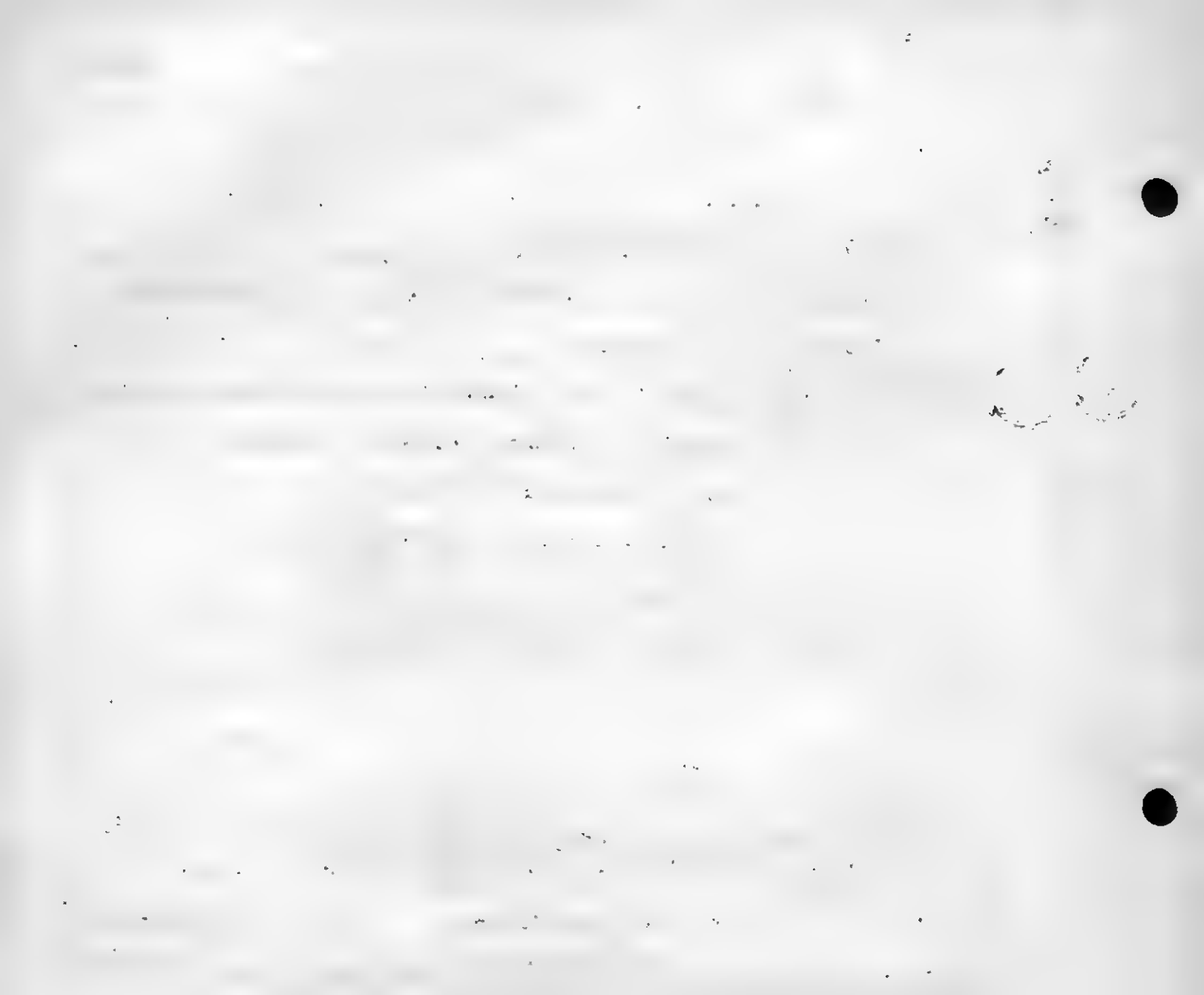


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon panels. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year			2b HOUR		
SAMUEL			J.		HAWKINS					10 9 68			1:40AM	
3. SEX		4 RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS.		
MALE		NGERO		4/18/89				79 YRS.		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
MARYLAND			U.S.A.						BALTIMORE					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD			VET. ADM. HOSPITAL			CHAUFFEUR			HOTEL					
13a. US/JAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1312 Eutaw Place.				
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last		
George					Hawkins				Mary			Jane Carter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16b SOCIAL SECURITY NO			17. INFORMANT Address					
YES			WW I			217 03 97 08			CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL UNDETERMINED ORGANISM														
4129 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last														
(b) ARTERIOSCLEROTIC HEART DISEASE														
DUE TO, OR AS A CONSEQUENCE OF														
(c) CARCINOMA COLON WITH METASTASES														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
420														
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			NO AUTOPSY				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
			HOUR A.M. Month Day Year P.M. 19											
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (for this hospital) attended the deceased from 9/10/68, 19 to 10/9/68, 19, that (if) (we) lost the deceased alive on 10/9/68, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.														
22b SIGNATURE												22c DATE SIGNED		
[Signature]												10/9/68		
22d PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.												22e ADDRESS		
												VAH FORT HOWARD, MARYLAND		
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL			10-14-68		BALTIMORE NATIONAL				BALTIMORE, MARYLAND					
24 FUNERAL DIRECTOR														
Vernon R. Bailey														
25a. REC'D BY REGISTRAR DATE 25b. REGISTRAR'S SIGNATURE														
KELSON FUNERAL HOME OCT 11 1968 Charles Judge														
1348 N. Calhoun St. Baltimore, Md.														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14017										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14028									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last James E Healy Sr										Month Day Year Oct 31 1968																			
3. SEX Male			4. RACE White			5. DATE OF BIRTH Jan 31 1912			6. AGE (In years last birthday) 56 YRS			7. UNDER 1 YEAR MONTHS DAYS			8. UNDER 24 HRS HOURS MIN														
7a. BIRTHPLACE (State or foreign country) Penn			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.																				
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Fitter			12b. KIND OF BUSINESS OR INDUSTRY Surgical Supp																				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Md			13b. COUNTY BALTO			13c. CITY OR TOWN PARKVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 2952 MANNING AVE																	
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Mary O'Connell																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No			16b. SOCIAL SECURITY NO. DWA 1946 212-03-274			17. INFORMANT June Healy			Address 2952 MANNING AVE.																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>400.4</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>5 YRS</u>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>222</u> <u>ASCVD</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>L.P. BERGER</u> DEGREE MED ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>11/1/68</u>																			
22d. PHYSICIAN'S NAME (Type) <u>S. ELLIOT HARRIS</u>										22e. ADDRESS <u>8100 HARTFORD RD</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <u>11-4-68</u>					23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>					23d. LOCATION (City or town) (County) (State) <u>BALTIMORE MD</u>														
24. FUNERAL DIRECTOR <u>CHAS. F. EVANS</u>										25a. REC'D BY REGISTRAR <u>NOV 4 1968</u>										25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)  
30M REV 12-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 23 Film G105 10-12-68 JK									
14018		14029							
1. DECEASED NAME (Type or print) First Middle Last <b>OWEN RAYMOND HEINTZ</b>						2a. DATE OF DEATH Month Day Year <b>10 12 1968</b>		2b. HOUR <b>2:20A M</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>4-18-1963</b>		6. AGE (In years last birthday) <b>5</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>child</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>100 Farview Court</b>	
14. FATHER'S NAME First Middle Last <b>Charles E. Heintz, Jr.</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Jean</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral edema due</b> DUE TO, OR AS A CONSEQUENCE OF <b>to Encephalopathy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>18</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <b>(u)</b> (this hospital) attended the deceased from <b>10-6</b> , 19 <b>68</b> , to <b>10-12</b> , 19 <b>68</b> , that <b>(x)</b> (we) last saw the deceased alive on <b>10-12</b> , 19 <b>68</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(x)</b> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. Cilliani</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-12-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>				22e. ADDRESS <b>7620 York Road, Towson 4, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>			
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

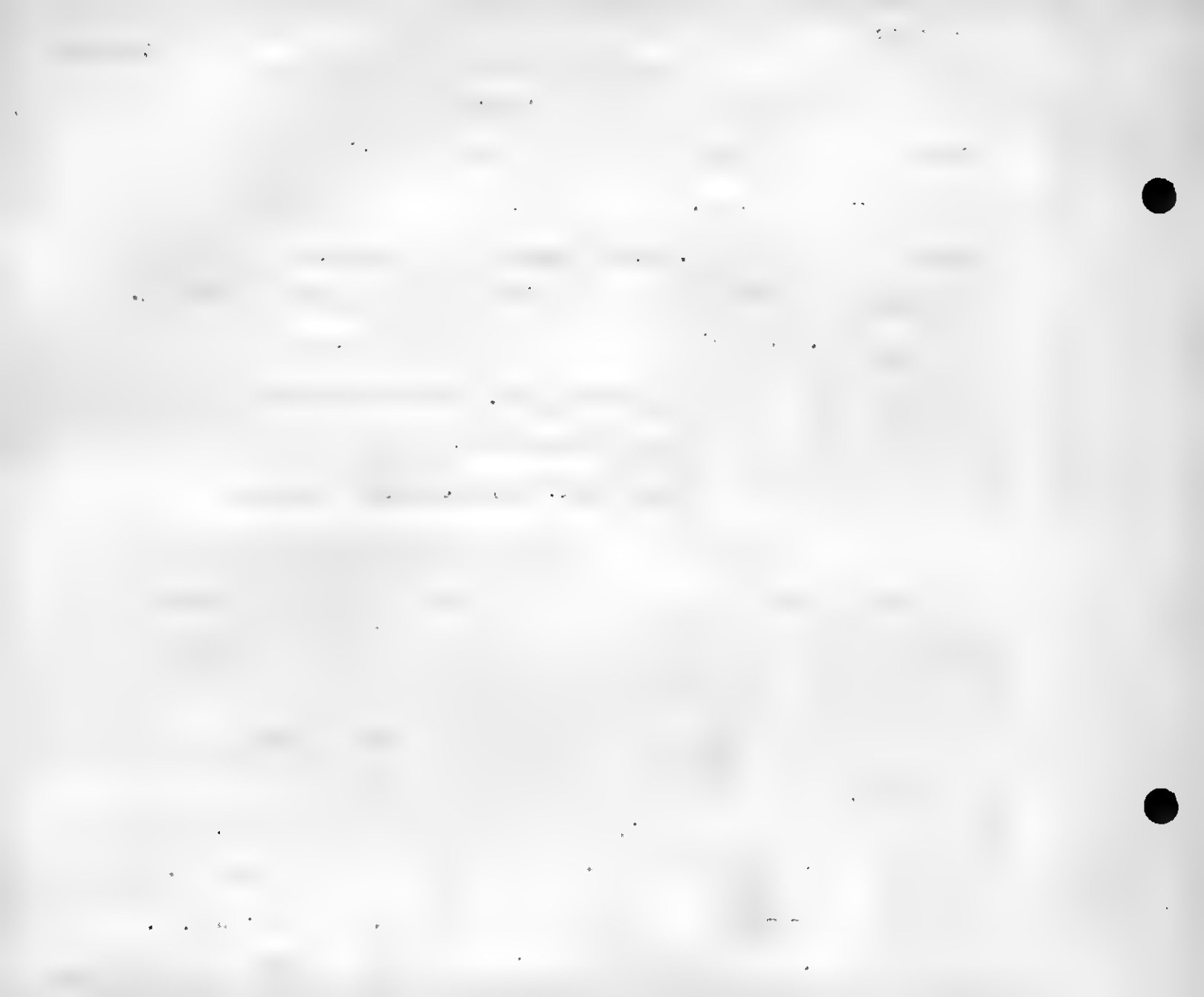


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
Virginia						Henderson		Month 10 Day 31 Year 1968		1 50 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		June 21, 1897				71 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
West Virginia		U.S.A.				Baltimore, Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital				Homemaker					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY L.H. 15?		13e STREET AND NUMBER			
Baltimore		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8804 Chardel Rd.			
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
John A. Stafford				Sarah (unknown)							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO		17 INFORMANT Address							
No		233-20-9961		Mrs. Charles Monkoria							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>4300</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cerebro vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a I certify that I (this hospital) attended the deceased from <u>10/31/</u> , 19 <u>68</u> , to <u>10/31/</u> , 19 <u>68</u> , that I (we) last saw the deceased alive on <u>10/31/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTERAR'S SIGNATURE	
Jaime M. Punzalan, M.D.		10/31/68				Jaime Punzalan, M.D.		7620 York Rd., Towson, Md. 21204		Charles Judge	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		11-2-69		Cunningham Memorial Cem.				Charleston W.Va.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		DATE			
Snodgrass F.H.		4122 McCorkle Ave				NOV 4 1968		Charleston W.Virginia			



14020

## CERTIFICATE OF DEATH

14031

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH 10/9/68		Month	Day	Year	2b. HOUR 4:30 M
3 SEX F		4 RACE W		5. DATE OF BIRTH 10/16/1881		6. AGE (in years lost birthday) 86		YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 625 Meyers Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 625 Meyers Dr., 21228		
14. FATHER'S NAME Henry J. Moseman		First	Middle	Last	15. MOTHER'S MAIDEN NAME Catherine Little		First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Joseph, 625 Meyers Dr., 21228						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A. S. C. V. disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u>										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Scrub typhus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>Oct 9</u> , 19 <u>68</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Oct. 9</u> , 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>(did)</u> <del>(did not)</del> view the body after death.										
22b. SIGNATURE <u>D. C. MacLaughlin</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/11/68				
22d. PHYSICIAN'S NAME (Type) Dr. D. C. MacLaughlin		22e. ADDRESS 303 N. Rolling Road, Baltimore, Md. 21228								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/14/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) Baltimore, Md.		(County)		(State)
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 11 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by a physician and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14022											
Item #6, Film G405 10/18/68 km											
CERTIFICATE OF DEATH											
14032											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
ALBERT		L.		HERRMANN		SR		10 Month 9 Day 68 Year		2:30 P. M.	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
M		W		10/21/1901		66 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md		U.S.A.				BALTO.					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CATONSVILLE		SHANGRA LA HOME		FOREMAN							
13a. US-JAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Md		BALTO.		CATONSVILLE				405 LAMBETH RD.			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
EMIL				HERRMANN				Helen		VON YON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No				213073410A		A.L. HERRMANN Jr.		405 LAMBETH RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a)										Cerebral vascular (Brain) artery occlusion 24 hrs	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										After cerebral Vaso. Disease	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)										to Left Cerebral Artery Occlusion 3 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 1960, to 10-9, 1968, that (I) (we) last saw the deceased alive on Oct 9 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
J. Nelson McKay M.D.		10/10/68		J. NELSON MCKAY, M.D.		6014 Edmonson Ave Balto. Md 21228					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		10/12/68		Schwartz Cem		BALTO. MD					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
E.S. Mac Nabb		301 Frederick Rd Balto. 21228		OCT 15 1968		J. Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
OSEIAN			E.		HICKMAN	Month 10 Day 9 Year 1968		4:12p M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Caucasian		Dec. 21, 1897		70 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Crisfield, Md.		USA				Baltimore Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		Greater Balto. Med. Center		Assist. Sec.		Credit Mgmt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.						156 Dumbarton Rd.	
14. FATHER'S NAME			First	Last	15. MOTHER'S MAIDEN NAME			First	Last
Wilmer Hickman					Alice				Massey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
yes			WW I		Mrs. Louise T. Hickman 156 Dumbarton Rd. #12				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage									10 days
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1968, to 10/9, 1968, that (I) (we) last saw the deceased alive on 10/9 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
Rudiger Breitenecker									10/10/68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Rudiger Breitenecker, M.D.					Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
burial		10/12/68		New Cathedral		Baltimore, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Mitchell-Wiedefeld Home 6500 York Rd.					OCT 17 1968		Charles Judge		
Balto., Md. 21212									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14022

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 5 & 6 Film

CERTIFICATE OF DEATH

14034

1. DECEASED-NAME (Type or print) First Middle Last Viola Christina Hillmeyer			2a. DATE OF DEATH Month Day Year Oct. 11, 1968		2b. HOUR 4 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 19, 1916		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co., Md.	
10. CITY OR TOWN OF DEATH Reisterstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 411 Dyer Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Voucher Clerk		12b. KIND OF BUSINESS OR INDUSTRY Army
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Reisterstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 411 Dyer Avenue	
14. FATHER'S NAME First Middle Last Frederick Hillmeyer			15. MOTHER'S MAIDEN NAME First Middle Last Helen Elizabeth Schonberger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO. 215-12-8707	17. INFORMANT Address Mrs. Helen Hillmeyer 411 Dyer Ave., Reisterstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma - breast</u> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to bone</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 7 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 17					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>December, 1963</u> , to <u>October 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>October 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>C.E. McWilliam, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED <u>October 11, 1968</u>	
22d. PHYSICIAN'S NAME (Type) H. J. Schaudt		22e. ADDRESS 11904 Reisterstown Rd Reisterstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR H. J. Schaudt		ADDRESS Owings Mills, Md.		25a. REC'D BY REGISTRAR DATE OCT 14 1968	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 10-27-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14024

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14035

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR			
DARRELL (DARRYL) HILTON						10-20 1968						M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			
Male		Negro		10-26-1952		16 YRS						Month Day Year			
												October 20, 1968			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
BALTIMORE		USA						BALTIMORE Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY			
TOWSON				Expressway Ruxton Road Overpass				STATIONER PUBLIC SCHOOLS							
13a USUAL RESIDENCE (Where deceased lived, if institution on, Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?			
Md.								Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e STREET AND NUMBER				14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
4114 Alton Road				Harvey Hilton				Evelyn Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT				ADDRESS			
NO								Evelyn Jones				5401 AS ADULT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Multiple severe injuries															
8151 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
8194															
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
CAUSE OF DEATH				7:40 AM 10-20-1968				Passenger in auto-fixed object collision							
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Expressway				Ruxton Road Overpass Baltimore Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				October 20, 1968			
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
								ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				10/23/68				ARABUTUS MEM PK				ARABUTUS - BALTIMORE 21227			
24 FUNERAL DIRECTOR				ADDRESS				25. REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John H. P. Hays				638 N Gilmore				OCT 26 1968				James J. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 10-1-64  
M REV 1-64

14025		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14036				
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
James Bruce Hoddinott						Oct. 6 1968		5:45 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
male		white		Nov. 3, 1891		76 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		USA				Baltimore				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson		1347 Yorktowne Drive		Proprietor		Steel				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		Baltimore		Towson				7347 Yorktowne Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
James Nicholas Hoddinott			Martha Burton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
no		165019679A		Emogene Hoddinott		same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
								3 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4221										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>Oct. 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct. 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
<u>A. Allan Spier</u>		10/7/68		A. Allan Spier M.D.		1501 Pentridge Rd.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10/9/68		Loudon Park Cem.		Baltimore, Md.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Leonard J. Ruck, Inc Baltimore, Md.				OCT 8 1968		Charles Judge				





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14026

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14037

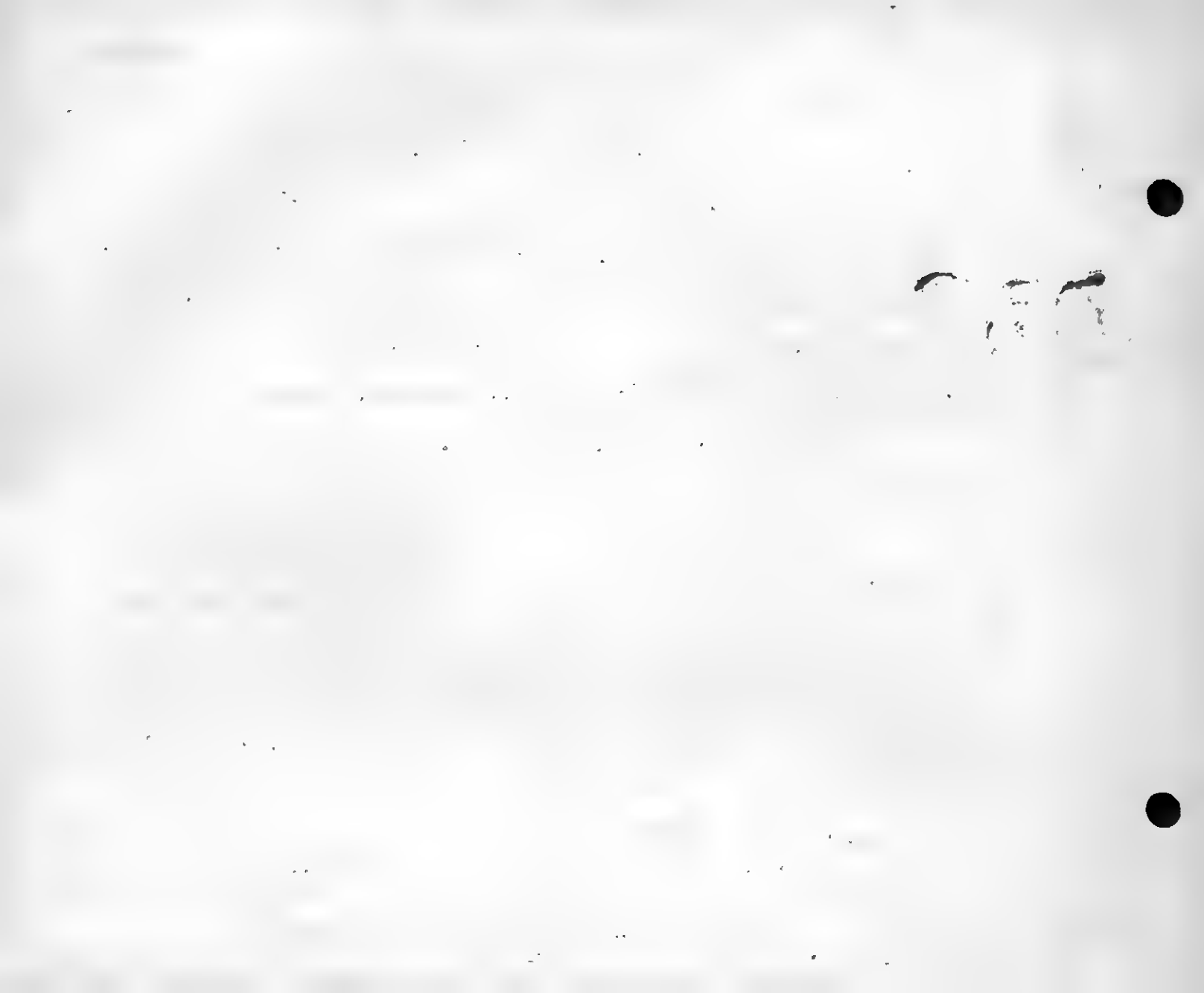
1. DECEASED-NAME (Type or print) <b>ERNEST CHARLES HOFFMAN</b>			2a. DATE OF DEATH <b>10</b> Month <b>24</b> Day <b>68</b> Year			2b. HOUR <b>12:30</b> P	
3 SEX <b>MALE</b>		4 RACE <b>CAU</b>		5 DATE OF BIRTH <b>9/3/96</b>		6 AGE (In years last birthday) <b>72</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>Del.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE, MARYLAND</b> Md	
10 CITY OR TOWN OF DEATH <b>Baltimore, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CENT. Maritime Eng.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>3051 Guilford Ave.</b>		14 FATHER'S NAME <b>Unknown</b>		15 MOTHER'S MAIDEN NAME <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>566-07-3106</b>		17 INFORMANT <b>Mrs. Stephen Szymanski</b>		Address <b>3015 Hudson St., Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>163x</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-25</b> , 19 <b>68</b> , to <b>10-24</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10-24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>ER Bondy</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-24-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>EDWARD R. Soudijn</b>				22e. ADDRESS <b>6701 N CHARLES ST BATT, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>10/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Matthews Funeral Home</b>				ADDRESS <b>3021 Eastern Ave</b>		25a. REG BY REGIS MAR <b>00128 1968</b> DATE <b>10-24-68</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14027		CERTIFICATE OF DEATH						14038	
1. DECEASED-NAME (Type or print) First John C. Middle Hofmeister Last				2a. DATE OF DEATH Month Day Year October 27 1968				2b. HOUR 7.50 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-11-1901		6. AGE (In years lost birthday) 67 YRS		7. UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Prop. Tavern		12b. KIND OF BUSINESS OR INDUSTRY Own			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY 13		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY (L.H.T.S?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6209 York Rd., 21212	
14. FATHER'S NAME First Middle Last John C. Hofmeister				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Garrison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-09-3016		17. INFORMANT Address Mrs. Lillian M. Hofmeister					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic-vascular heart disease</u> 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-25-1968</u> , to <u>10-27-1968</u> , that (I) (we) last saw the deceased alive on <u>10/27/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Camilo E. Tomboc				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-27-68			
22d. PHYSICIAN'S NAME (Type) Camilo E. Tomboc MD				22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Road-21212				25a. REC'D BY REGISTRAR NOV 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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1

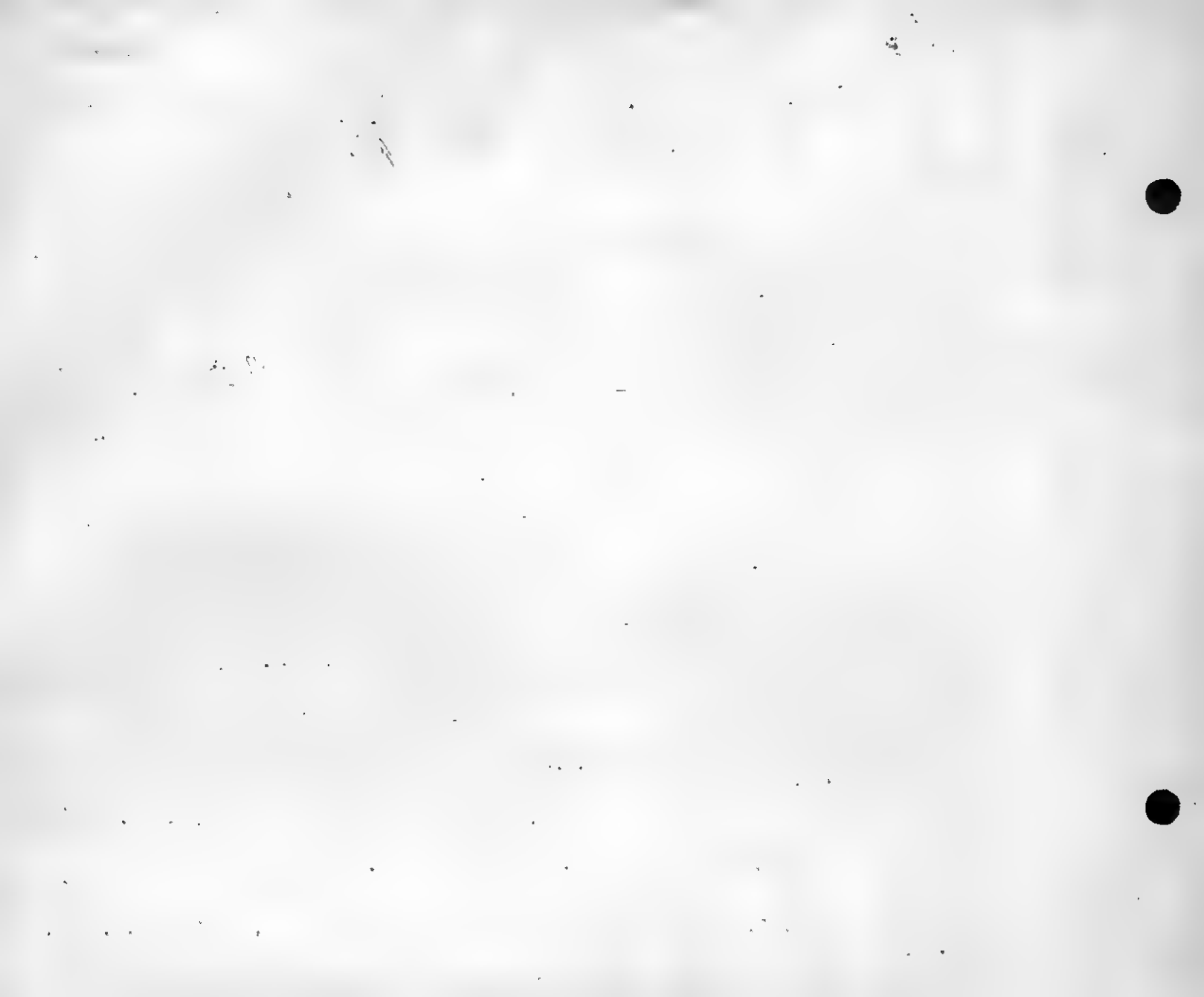
14028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14039

1. DECEASED NAME (Type or print) <b>BEULAH E. HOLLINS</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>2</b> Year <b>1968</b> P.M.		
3 SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>9-22-29</b>		6. AGE (In years last birthday) <b>39</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>BALTO Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self empl.</b>			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>House in the Pines</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Baby Sitter</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Davidsonville</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>--</b>			
14. FATHER'S NAME First <b>Joseph</b> Middle <b>Stuart</b> Last <b>Ward</b>			15. MOTHER'S MAIDEN NAME First <b>Georgetta</b> Middle <b>Jackson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>212-36-59-534</b>		17. INFORMANT <b>1817 Alder Vista Ave., Baltimore, Md. 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ASCVD</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4129</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly med cal examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1968</b> to <b>Sept 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Earl Pass MD</b>		22c. DATE SIGNED <b>10-2-68</b>		22d. PHYSICIAN'S NAME (Type) <b>EARL PASS MD</b>	
22e. ADDRESS <b>1001 W. Johns Ave</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davidsonville Methodist</b>	
23d. LOCATION (City or Town) (County) (State) <b>Davidsonville A.A. Md.</b>		24. FUNERAL DIRECTOR <b>Beulah E. Hopping</b> <b>HOPPING FUNERAL HOME - Annapolis, Md.</b>			
25a. REC'D BY REGISTRAR <b>OCT 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14028		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14040	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) <i>Louise Augusta Hopper</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>25</i> Year <i>1968</i>			2b. HOUR M <i></i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>9-2-1880</i>		6. AGE (In years last birthday) <i>88</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S. G.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Balto. County</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>aged women's home 615 Chestnut St. House 4150</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>N. J.</i>		13b. COUNTY <i>—</i>		13c. CITY OR TOWN <i>Norwood</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>586 Laurel Road</i>		14. FATHER'S NAME First <i>Warren</i> Middle <i>H.</i> Last <i>Hopper</i>		15. MOTHER'S MAIDEN NAME First <i>Louise Augusta</i> Middle <i>Hopper</i> Last <i>—</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO <i>215 52 2408</i>		17. INFORMANT <i>Frances M. Strickus 615 Chestnut St.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hours</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>42</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1956</i> , 19 <i>—</i> , to <i>10-25</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/24</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Memlane E Day M.D.</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>October 25, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Memlane E Day</i>		22e. ADDRESS <i>4-2-33rd St Balto. Md 21218</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>10-28-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE MD</i>	
24. FUNERAL DIRECTOR <i>W. Cook-Brooks Towson</i>		ADDRESS <i>1050 York Rd Towson, Md</i>		25a. REC'D BY REGISTRAR <i>DATE OCT 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

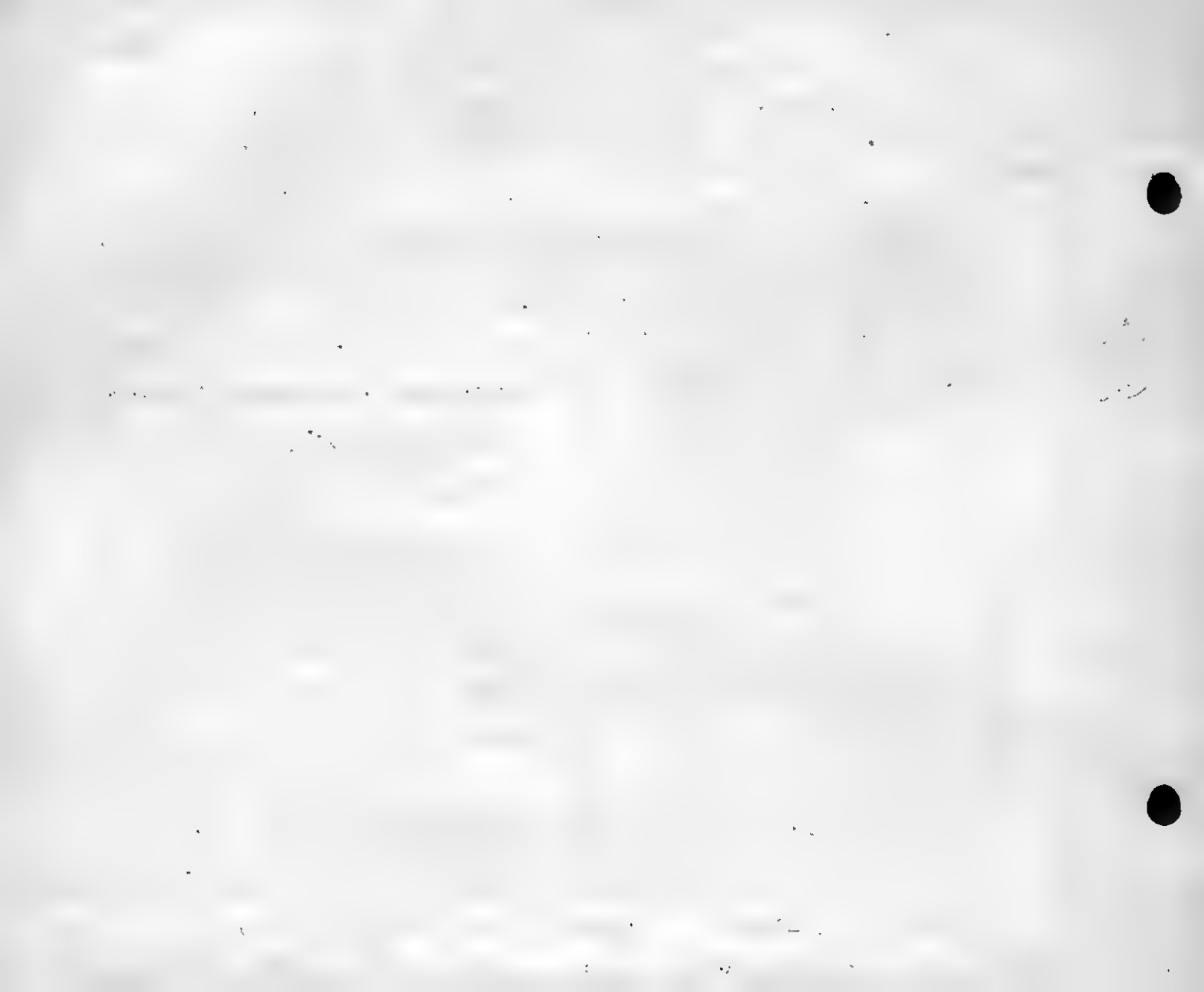




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14030		CERTIFICATE OF DEATH						14041	
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M
Jeannette			Houst			Oct 27 1968			
3 SEX	4 RACE	5. DATE OF BIRTH				6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White	July 1 1906				62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		USA				Baltimore Co Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR IND. STRY
Woodlawn			1506 Barrett Rd			Sales			Dep't Store
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Baltimore		Woodlawn			1506 Barrett Rd	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John R Stewart			Mary Etta Parker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
no			no		212-26-5630 Robert Houst 1506 Barrett Rd Balto Md 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Oct 25, 1968, to Oct 27, 1968, that (I) (we) last saw the deceased alive on Oct 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kennard Yaffe M.D.				DEGREE ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/28/68	
22d. PHYSICIAN'S NAME (Type) KENNARD YAFFE				22e. ADDRESS 5501 Forest Park Ave					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		10-30-68		Baltimore National Cem		Baltimore, Md			
24. FUNERAL DIRECTOR Thomas J. Kenny Inc				ADDRESS 1600 Hollins St		25a. REC'D BY REGISTRAR DATE OCT 29 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

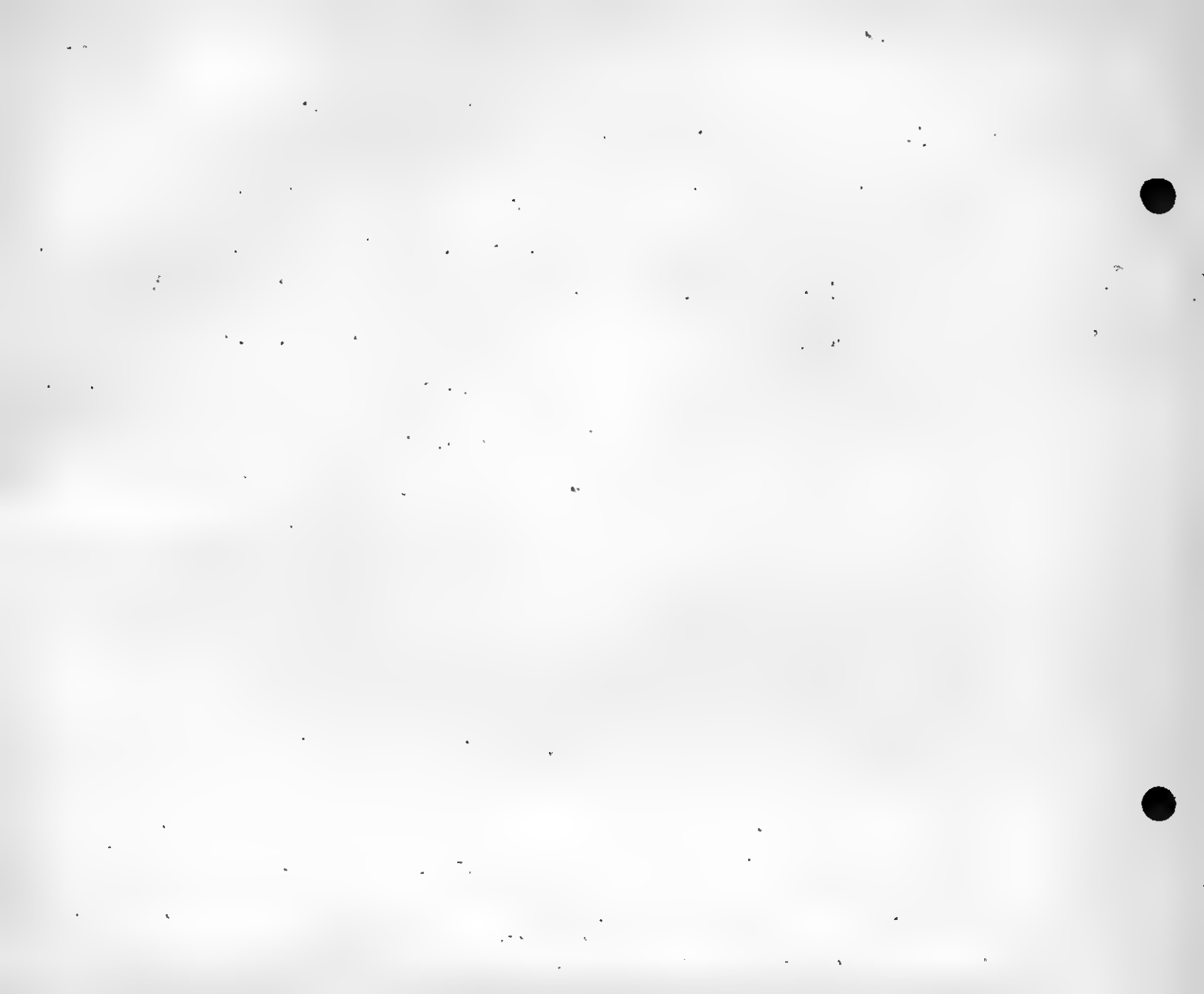


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
Julia			M.		Howard				Oct Month 20 Day 1968		M		
3 SEX		4. RACE		5 DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Fe		White		2-3-1883			85 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland			USA					Baltimore Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Garrison, MD				Forleigh Convalescent Center				Home maker			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland				BALTO		Cockeysville		YES <input type="checkbox"/> NO <input type="checkbox"/>		24 G BRONS Blvd 21030			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
Joshua			GREEN						Mary Elizabeth			Martin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO		17 INFORMANT			Address				
				219-14-2303		MRS Edna Warner			24 G BRONS BLVD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Myocardial Ischemia													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Acute Myocardial Infarction - old ECG													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
7-2-11													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8-15, 1968, to 10-20, 1968, that (I) (we) last saw the deceased alive on 10-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Vicente M Ruano MD										10-20-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
VICENTE M RUANO						Spring Grove State Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			10-23-68		MUNKTON			MUNKTON MD					
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm Cook - Brooks Towam Towson MD 21204						1050 York Rd			DATE OCT 22 1968		J Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A154  
30M REV 7/68

14032

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

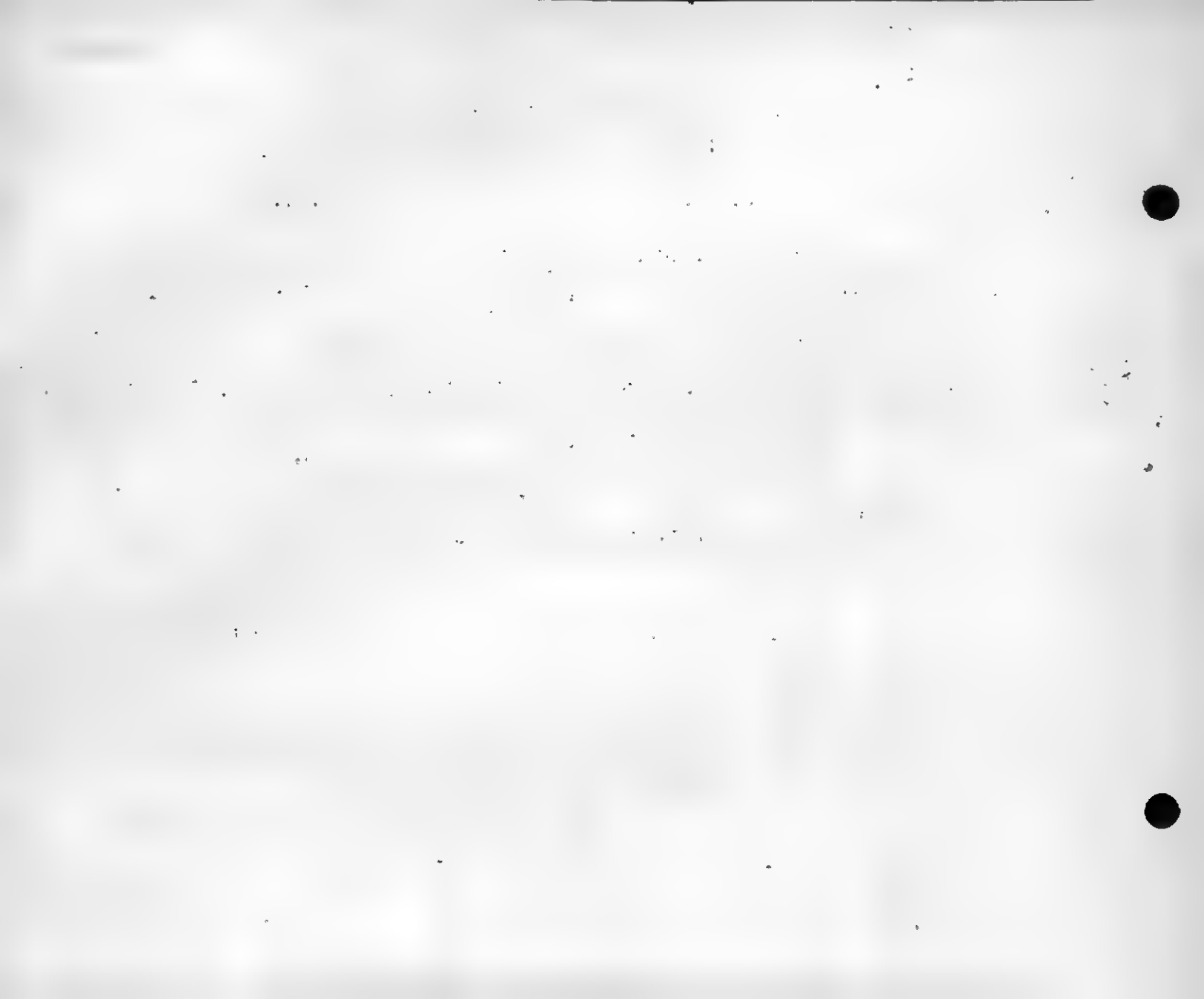
CERTIFICATE OF DEATH

14043

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
WILLIAM BOWEN HUDSON						10 20 68			6:00 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		4/16/05		63 YRS					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE Md.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work and life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		VET. ADM. HOSPITAL		BARTENDER							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
MARYLAND				BALTIMORE				700 HARVEY STREET			
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOHN HUDSON						CECILIA O'CONNER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war and dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address						
YES WW II			217 09 90 31		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIC SHOCK									4 DAYS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEPATIC FAILURE (LAENNEC'S CIRRHOSIS)									1 WEEK		
(c) CARCINOMA OF SIGMOID COLON									UNKNOWN		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY?											
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED											
21e. LOCATION											
21f. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
22a. I certify that (1) (this hospital) attended the deceased from 7/15/68, 19__, to 10/20/68, 19__, that (1) (we) last saw the deceased alive on 10/20/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (Type)											
22e. ADDRESS											
23a. BURIAL, CREMATION, or other final disposition											
23b. DATE											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City or Town) (County) (State)											
24. FUNERAL DIRECTOR											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											

MC CULLY FUNERAL HOME  
134 E. Fort Ave. Baltimore Md.  
OCT 28 1968

Charles Judge



14038

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14044

1. DECEASED NAME (Type or print) <i>Minnie G Hutchins.</i>			2a. DATE OF DEATH 10 Month 30 Day 68 Year			2b. HOUR 12:30 P.M.		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 1, 1869</i>		6 AGE (In years lost birthday) <i>99</i> YRS		
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore Co.</i> Md		
10. CITY OR TOWN OF DEATH <i>Catoonsville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>823 Stamford Rd</i>								
14. FATHER'S NAME <i>Joseph F. Cambrell</i>			15. MOTHER'S MAIDEN NAME <i>MARY JANE YOUNG</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT <i>MRS BESSIE MEERS</i>			
					Address <i>823 STAMFORD RD</i>			

## 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) *SQUAMOUS CELL CARCINOMA LEFT*DUE TO, OR AS A CONSEQUENCE OF *CHEEK AND LEFT JAW*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/25, 1968</i> to <i>10/30, 1968</i> , that (I) (we) last saw the deceased alive on <i>10/29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>E. Kasaitis, M.D.</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>10/30/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>E. KASAITIS, M.D.</i>				22e. ADDRESS <i>1801 FREDERICK ROAD BALTO 21228</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>11-2-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LODGE PARK</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE MD.</i>	
24. FUNERAL DIRECTOR <i>St. Howard's</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE <i>NOV 4 1968</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tag-top papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





CERTIFICATE OF DEATH

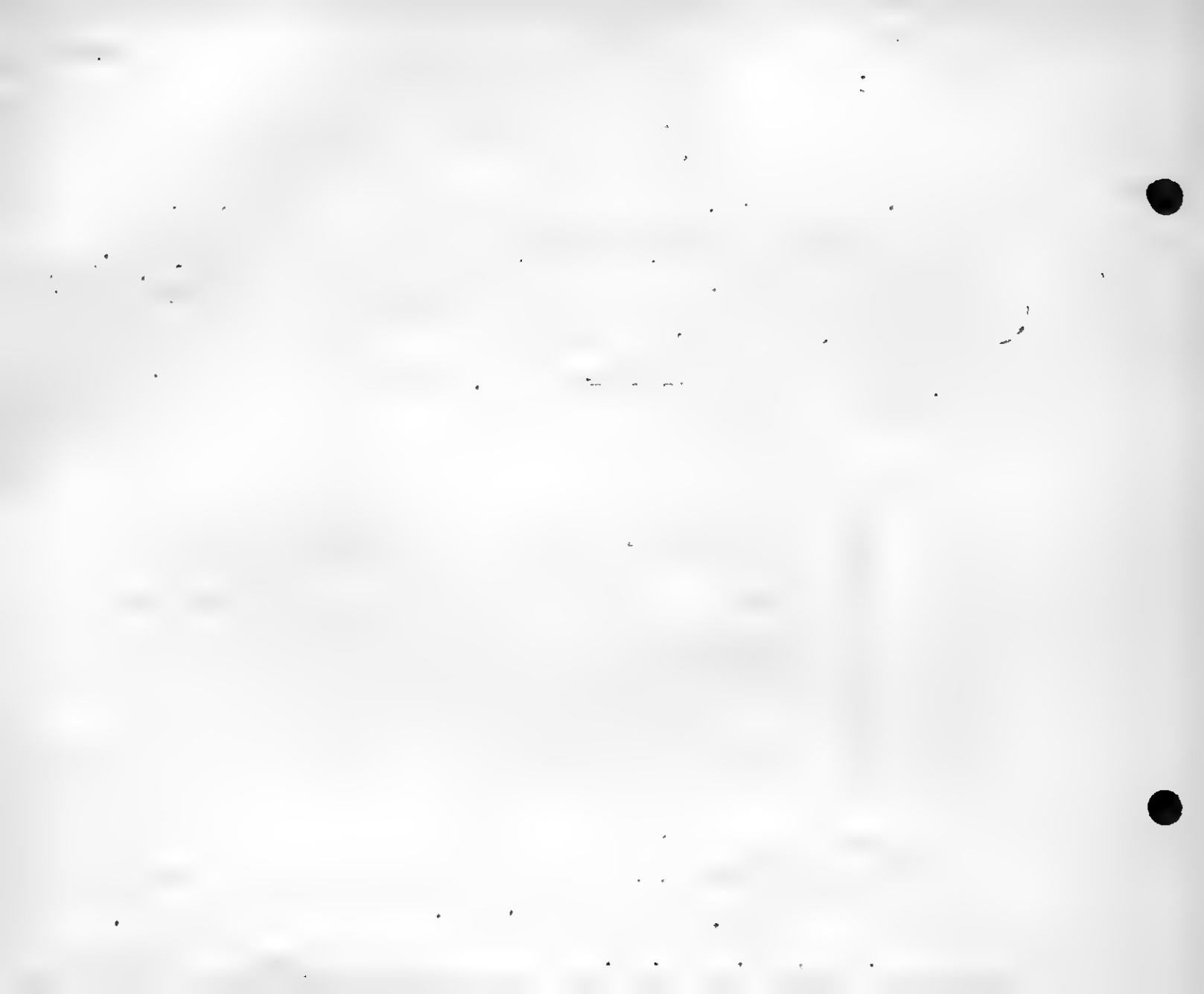
14034

14045

1. DECEASED-NAME (Type or print) First Middle Last Emma R. Hutchinson			2a. DATE OF DEATH Month Day Year October 26 1968			2b. HOUR 8:10 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-12-1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 19 E. Midland Rd #20	
14. FATHER'S NAME First Middle Last Robert Hutchinson			15. MOTHER'S MAIDEN NAME First Middle Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 182-09-2588-0538		17. INFORMANT Mrs. Vivian Mattingly		Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 551.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hiatal Hernia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophageal Rupture</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/26/1968, to 10/26/1968, that (I) (we) last saw the deceased alive on 10/26/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ines Gilliani, M.D.				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/27/68	
22d. PHYSICIAN'S NAME (Type) Ines Gilliani, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21264					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68.		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card-box papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 435 (4)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
14035 CERTIFICATE OF DEATH 14046																	
1 DECEASED-NAME (Type or print)			First <b>PAUL</b>			Middle <b>F.</b>			Last <b>JACOB, SR.</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>68</b>			2b. HOUR <b>2:35P M</b>		
3 SEX <b>MALE</b>			4 RACE <b>WHITE</b>			5 DATE OF BIRTH <b>6/1/92</b>			6. AGE (in years last birthday) <b>76</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md								
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>BAKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>418 N. Bend Road</b>					
14. FATHER'S NAME First <b>LOUIS</b>			Middle <b>JACOB</b>			Last <b>MARGARETTE</b>			15 MOTHER'S MAIDEN NAME First <b>DETTRICH</b>			Middle <b>DETTRICH</b>			Last <b>DETTRICH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>YES</b>			(If yes give war or dates of service) <b>WW I</b>			16b. SOCIAL SECURITY NO <b>005 32 84 41</b>			17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, RECENT</b> DUE TO, OR AS A CONSEQUENCE OF <b>ADENOCARCINOMA PROSTATE WITH HEMORRHAGE, OLD AND RECENT</b> (b) <b>METASTATIC ADENOCARCINOMA, PELVIC</b> DUE TO, OR AS A CONSEQUENCE OF <b>WALL AND REGIONAL LYMPH NODES, OLD</b> (c) <b>WALL AND REGIONAL LYMPH NODES, OLD</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ARTERIOSCLEROTIC HEART DISEASE, OLD</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/20/68</b> , 19____, to <b>10/7/68</b> , 19____, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>10/7/68</b> , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																	
22b. SIGNATURE 			DEGREE <b>MD</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10/8/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>GEORGE McELPATRICK, M.D.</b>			22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10/11/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>								
24. FUNERAL DIRECTOR			ADDRESS <b>WITZKE FUNERAL HOME</b>			25a. REC'D BY REGISTRAR <b>4101</b>			25b. REGISTRAR'S SIGNATURE <b>8 1968</b> 								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1-68

14036

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14047

1. DECEASED NAME (Type or print) <b>IDA</b>			First Middle Last			2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>1:30 A.M.</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>APRIL 1899</b>			6. AGE (In years last birthday) <b>69</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3104 FAIRVIEW ROAD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SALESLADY</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <b>HARRIS</b> Middle <b>LUNTZ</b> Last <b>?</b>			15. MOTHER'S MAIDEN NAME First <b>LENA</b> Middle <b>?</b> Last <b>?</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>216-16-9328</b>		
17. INFORMANT Address <b>MRS. ANNETTE STEEL, 3104 FAIRVIEW RD. #21207</b>			18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY <b>41d</b> IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS?</b> <b>?</b> <b>2 YRS</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <b>NONE</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-20</b> , 19 <b>68</b> , to <b>10-16</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-8</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Leon Ashman M.D.</b>						22c. DATE SIGNED <b>10-17-68</b>			22d. PHYSICIAN'S NAME (Type) <b>LEON ASHMAN</b>		
22e. ADDRESS <b>5907 GWYNNE OAK AVENUE</b>						23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10-17-68</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE NESNIA</b>						23d. LOCATION (City or Town) (County) (State) <b>ROSEDALE, MARYLAND</b>			24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		
25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

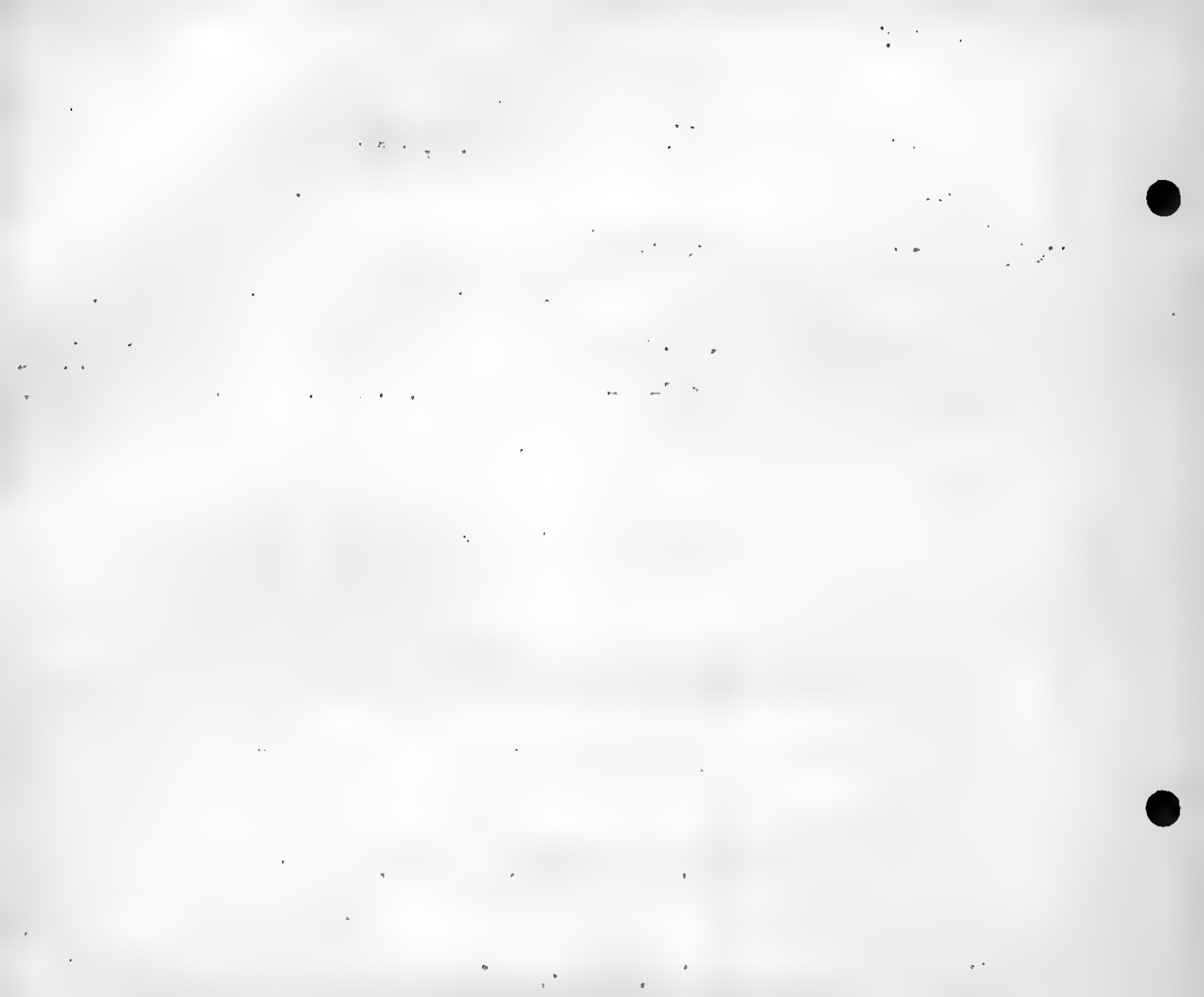
14037

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14048

1 DECEASED NAME (Type or print) <b>MARY</b>			First Middle Last <b>JAMES</b>			2a. DATE OF DEATH Month Day Year <b>October 26 1968</b>			2b. HOUR <b>12:35</b>		
3 SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>Dec. 9, 1889</b>			6 AGE (In years) <b>78</b> YRS		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Charles A. Singewald</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Catherine Wessling</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO <b>212-10-8353D</b>		
17. INFORMANT <b>John A. James, 606 Washington Ave.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>331x</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-25-68</b> , 19 <b>68</b> , to <b>10-26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Beatriz P. Diszon</b>						DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>10-26-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Beatriz P. Diszon, M.D.</b>						22e. ADDRESS <b>St. Joseph's Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10/29/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co., 4905 York Rd. Balto. 12, Md.</b>						25a. REC'D BY REGISTRAR <b>OCT 28 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





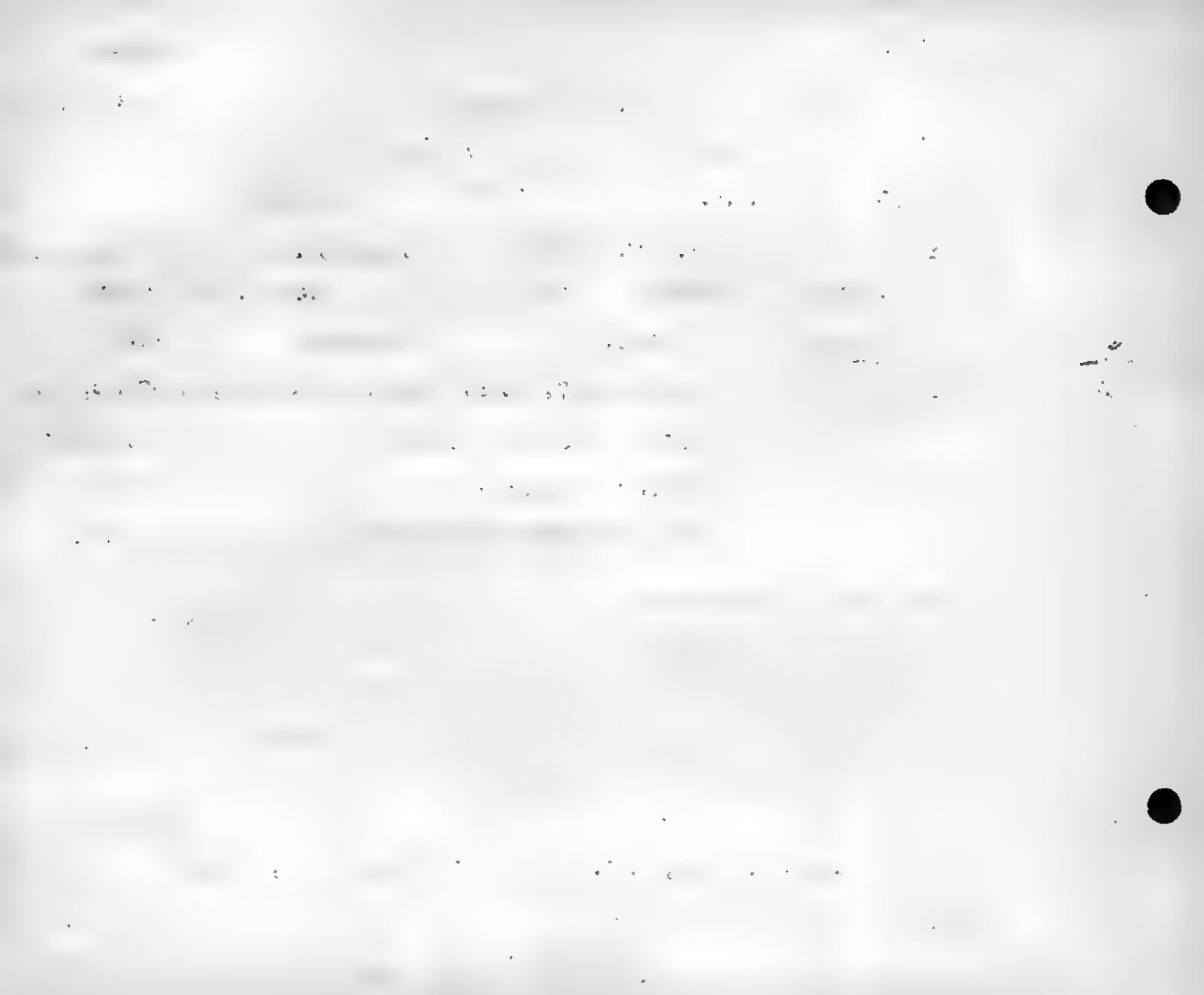
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15-41  
30M REV 1-59

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
14038				CERTIFICATE OF DEATH				14049					
1. DECEASED-NAME (Type or print) <b>DAVID</b>				First Middle Last <b>Howard JOESTING</b>				2a. DATE OF DEATH Month <b>10</b> Day <b>1</b> Year <b>68</b>				2b. HOUR <b>8:20A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>8/17/14</b>				6. AGE (In years last birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>						Md.	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CONSTRUCTION</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>BEL AIR</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1401 S. KELLY AVENUE</b>			
14. FATHER'S NAME First Middle Last <b>WILLIAM JOESTING</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>ELIZABETH FOUTZ</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>YES WW II</b>				16b. SOCIAL SECURITY NO <b>574 03 96 79</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PASSIVE CONGESTION OF HEART</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC COR PULMONALE</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO AUTOPSY</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (X) (this hospital) attended the deceased from <b>9/23/68</b> , 19__, to <b>10/1/68</b> , 19__, that (X) (we) last saw the deceased alive on <b>10/1/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Peter V. Juvan</i>								DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/1/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>				22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>									
23a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		23b. DATE <b>October 3, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR Memorial Gardens</b>				23d. LOCATION (City or Town) (County) (State) <b>BEL AIR, Harford Co., Maryland 21041</b>					
24. FUNERAL DIRECTOR <i>Charles Judge</i>				ADDRESS <b>FOSTER FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>OCT 3 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14

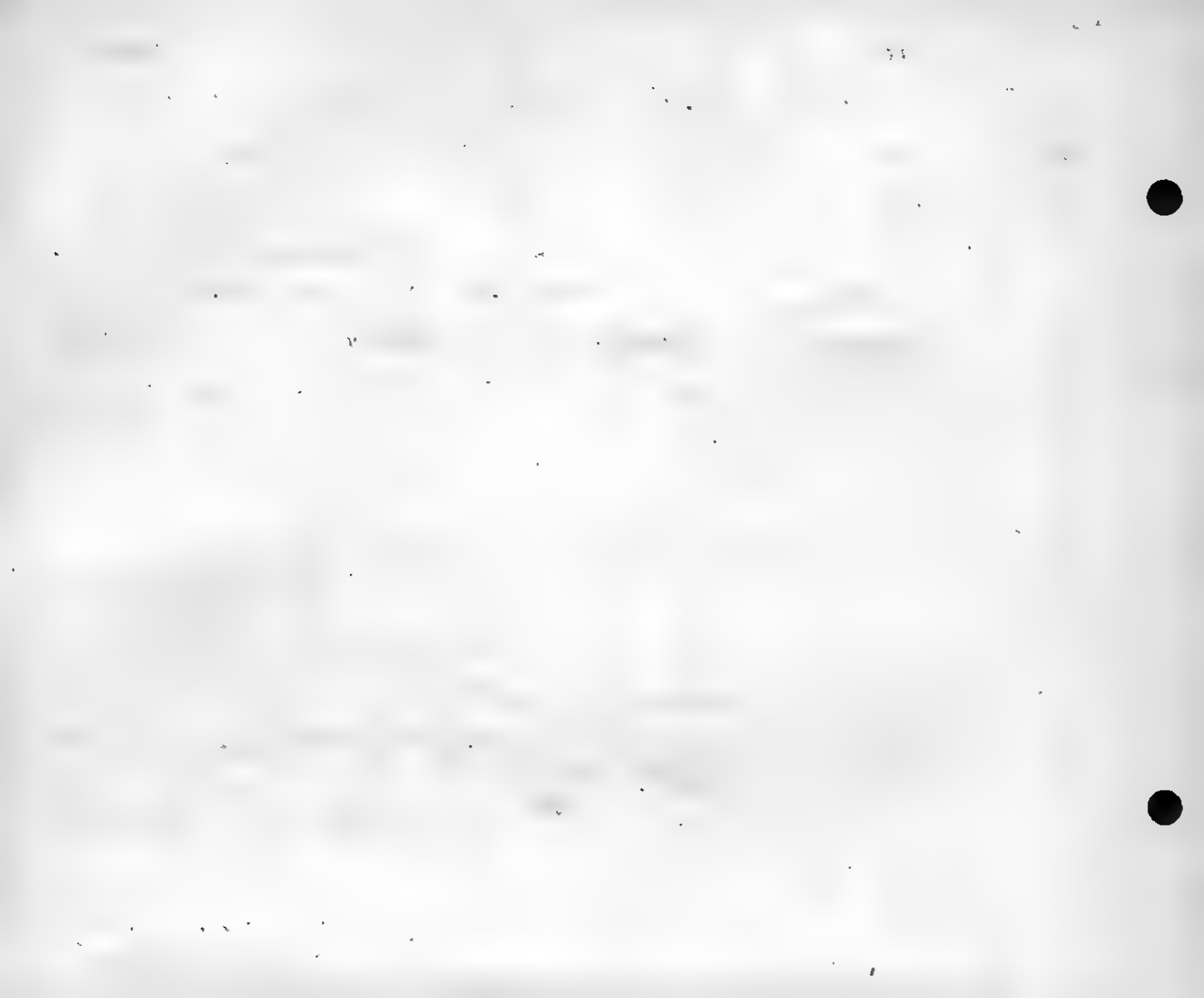
16032

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14050

1. DECEASED-NAME (Type or print) <b>DAVID JESSE JOHNSON</b>			2a. DATE OF DEATH <b>OCT</b> Month <b>9</b> Day <b>1968</b>			2b. HOUR <b>6:30</b> PM				
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>9/22/1917</b>		6. AGE (In years last birthday) <b>71</b> YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md.				
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mount Wilson State Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>REPAIRMAN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FURNITURE</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>138</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1027 BENNETT PLACE</b>	
14. FATHER'S NAME First Middle Last <b>RICHARD JOHNSON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY JACKSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>215-18-5760</b>		17. INFORMANT Address <b>Records, Mount Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> <b>492X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5271</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>① MAIN PULM. ART. THROMBOS. EMBOLUS, OVS. &amp; PULM. TRX (R. O.)</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <b>W</b> (this hospital) attended the deceased from <b>7/29</b> , 19 <b>68</b> , to <b>9 OCT</b> , 19 <b>68</b> , that <b>W</b> (we) last saw the deceased alive on <b>9 OCT</b> , 19 <b>68</b> , and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>W</b> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W Newcomer</b>				22c. DATE SIGNED <b>9 OCT 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				
22e. ADDRESS <b>Mount Wilson, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/14/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co., Maryland</b>			
24. FUNERAL DIRECTOR <b>Herbert E. Nutter-20 5 W. North Ave.</b>				25a. REC'D BY REGISTRAR <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14040					14051				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First		Middle		Last	Month		Day	Year	HOUR
EVA		NMN		JOHNSON	10		Y	1968	12:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
Female		Negro		9-9-1925		43 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during past of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		Greater Balto. Med. Center		Domestic					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		1		City		YES		325 E. Lanvale St	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
James R. Markins		Lucy Thornton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
				Juanita Thompson		414 Titman Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral hemorrhage									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) Hypertension									20 hours
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
					YES		YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1968, to 10/1, 1968, that (I) (we) last saw the deceased alive on 10/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Charles C. Brown, M.D.								10/1/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Charles C. Brown, M. D.				Greater Baltimore Medical Center					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-5-68		Mt Calvary Cem Co. Co		Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Kathleen Sanders				2177 P...		OCT 8 1968		Charles J. J...	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

14041

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14052

1 DECEASED NAME (Type or Print) <b>MALCOLM E. JOHNSON</b>			2a DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10/25/68 19			2b HOUR <b>UNK M</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5 DATE OF BIRTH <b>April 7th, 1929</b>	6 AGE (in years last birthday) <b>39 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS HOURS M.M. <b>0 0</b>	2c DATE PRONOUNCED DEAD Month Day Year <b>October 25, 1968</b>	2d HOUR <b>8:02 P.M.</b>
7a BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore Md</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Exec Dir</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Childred Assn.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <b>1030 Marlow Drive</b>	
14 FATHER'S NAME First Middle Last <b>Malcolm D. Johnson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Marjorie Fillmore</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>Korea 216-24-7486</b>		17. INFORMANT <b>Mrs. M. Elizabeth Johnson-1030 Marlow Dr 12</b>			ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcoholic Intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>10/26/68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd-21212</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

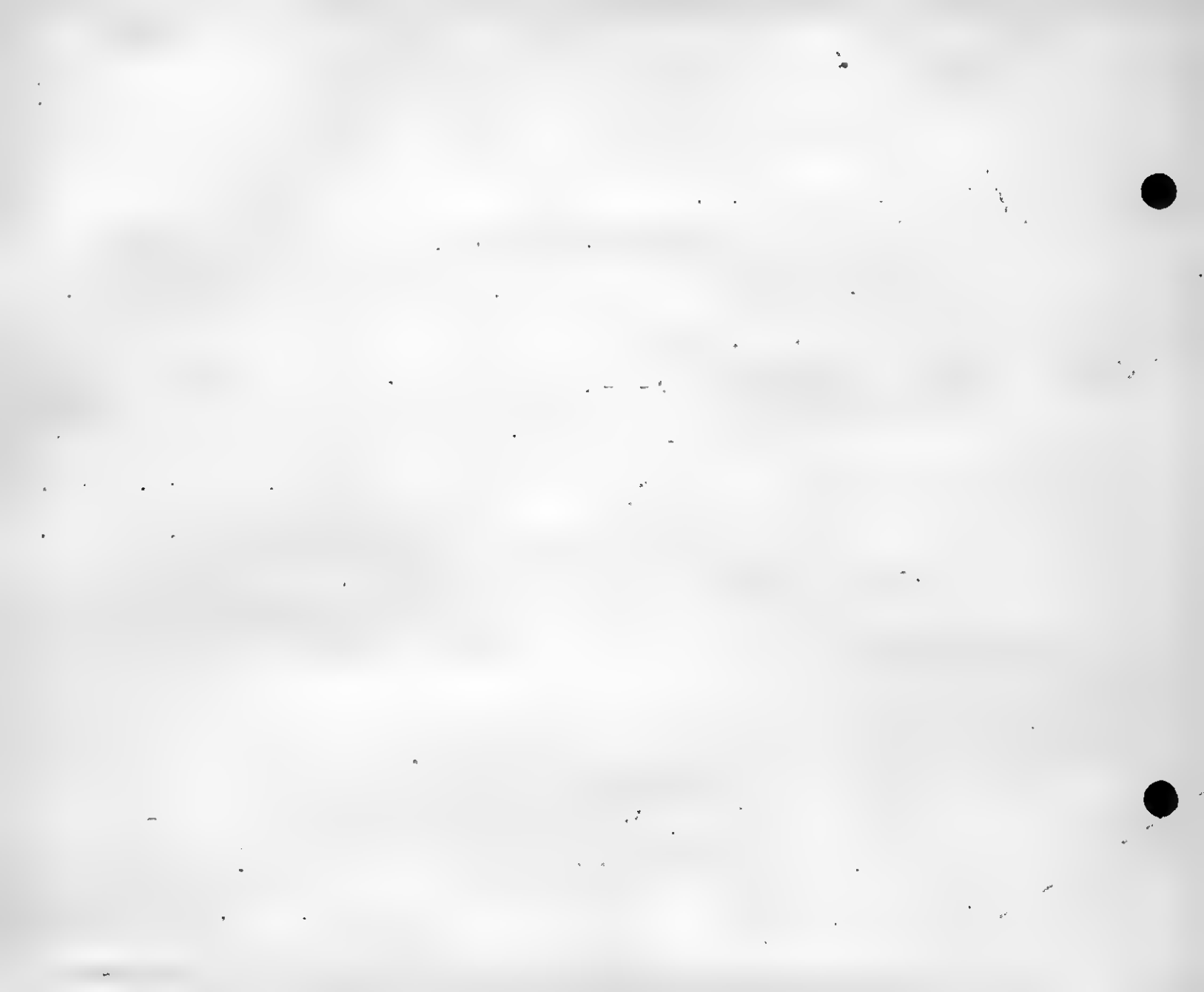




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Item 20a Film 406 17-1-68 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14053
14044												
1. DECEASED-NAME (Type or print) First Middle Last Watt Tyler Johnson						2a. DATE OF DEATH Month Day Year October 25, 1968						2b. HOUR 10:30 M
3. SEX male		4. RACE Negro		5. DATE OF BIRTH April 16, 1910		6. AGE (in years last birthday) 58 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b. KIND OF BUSINESS OR INDUSTRY fertilizer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2838 West Mulberry St. plant
14. FATHER'S NAME First Middle Last Charles C. Johnson						15. MOTHER'S MAIDEN NAME First Middle Last Rose						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) 33726274			16b. SOCIAL SECURITY NO. 1945 Army			17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death												immediate
410.7 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												(b) Arteriosclerotic, Cardiovascular Ht.Dis. 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF												(c) Arteriosclerosis, Generalized, Senile. 5 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary Emphysema and chronic Bronchitis.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from Dec. 13, 1966, to Oct. 25, 1968, that (I) (we) saw the deceased alive on Oct. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Anthony J. Young</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-25-68				
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.						22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-31-68		23c. NAME OF CEMETERY OR CREMATORY Church Cem.		23d. LOCATION (City or town) (County) (State) Westmontland Co. VA						
24. FUNERAL DIRECTOR V.R. Bailey Kelson Funeral Home 1348 N. Calhoun St						25a. REC'D BY REGISTRAR DATE OCT 29 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



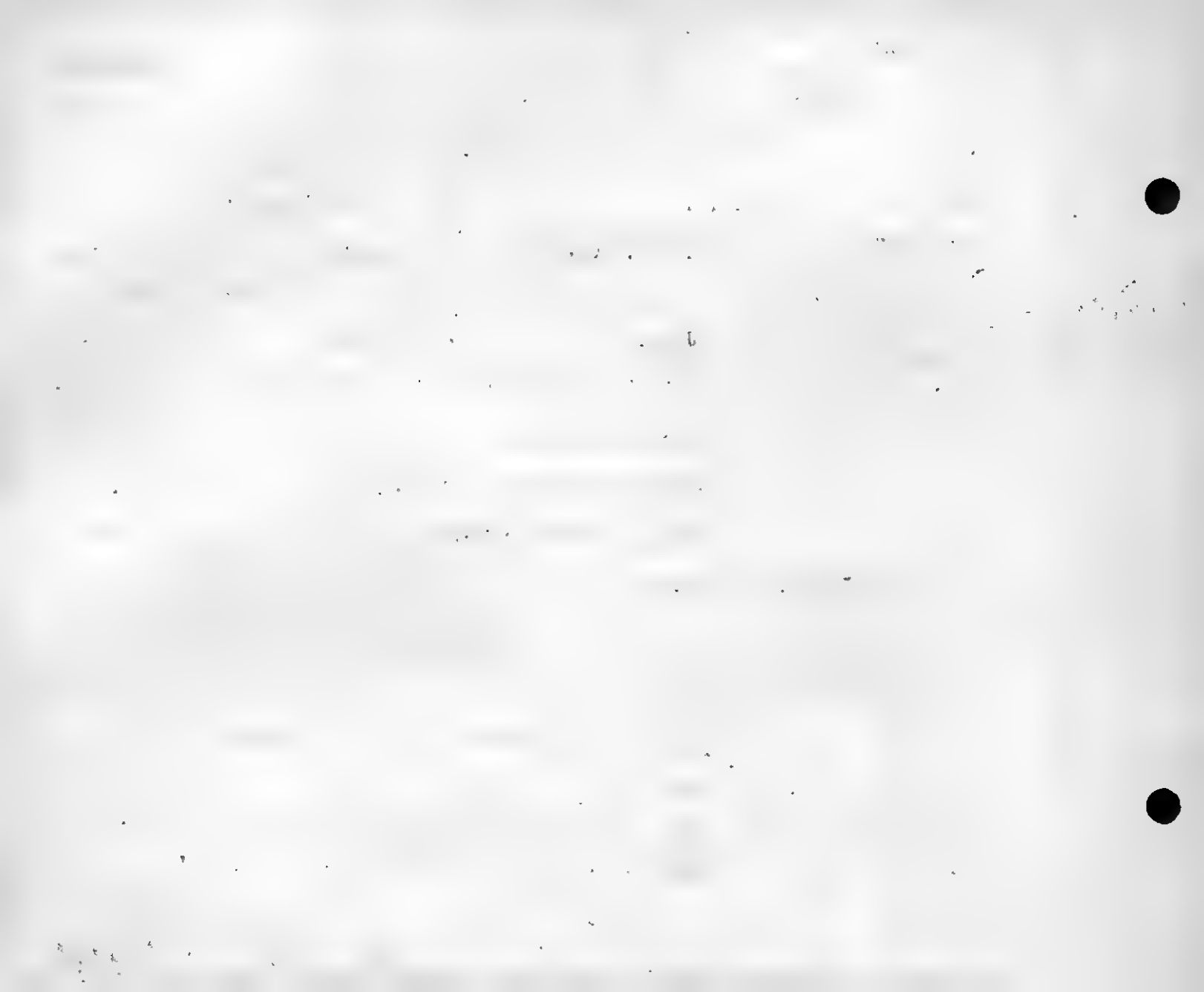
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

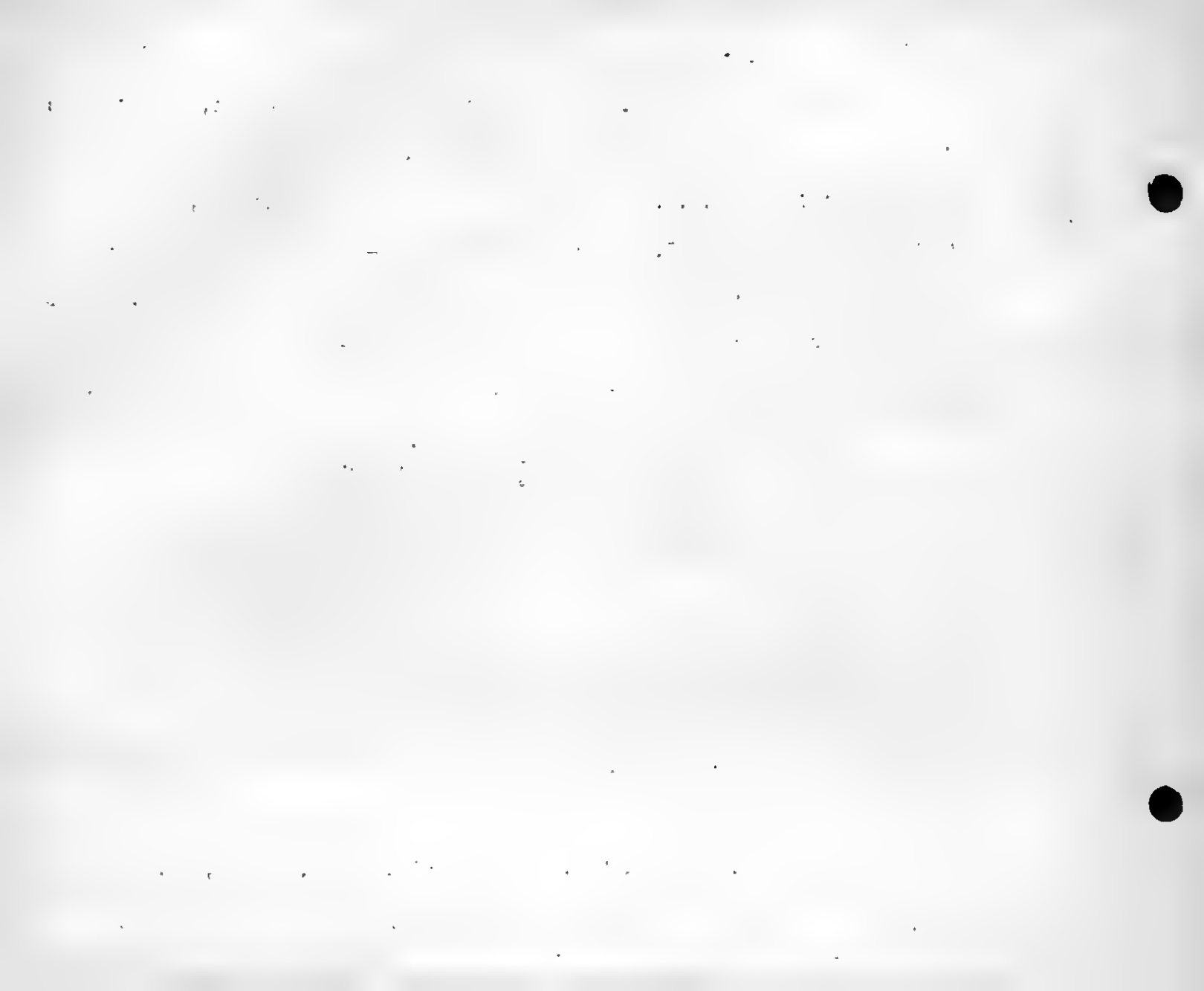
1. DECEASED-NAME (Type or print) <b>MACON</b>		First Middle Last		2a. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>68</b>		2b. HOUR <b>6:00PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>6/3/96</b>		6. AGE (In years last birthday) <b>72</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY</b> Md.	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL CO.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>JOHN JONES</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>LENORA THOMPSON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give branch and dates of service) <b>WW I</b>			
16b. SOCIAL SECURITY NO. <b>219 05 04 32</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADENOMA, PITUITARY GLAND</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4127</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>  <b>OLD</b>  <b>OLD</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>BENIGN PROSTATIC HYPERTROPHY, OLD</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <b>10/1/68</b> , 19____, to <b>10/7/68</b> , 19____, that (1) (we) last saw the deceased alive on <b>10/7/68</b> , 19____, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Erhard J. Bunyor</b> , DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/8/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ERHARD J. BUNYOR, M. D.</b>				22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/11/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Charles A Rice</b>		ADDRESS <b>661 W. Barre St. Baltimore, Md.</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



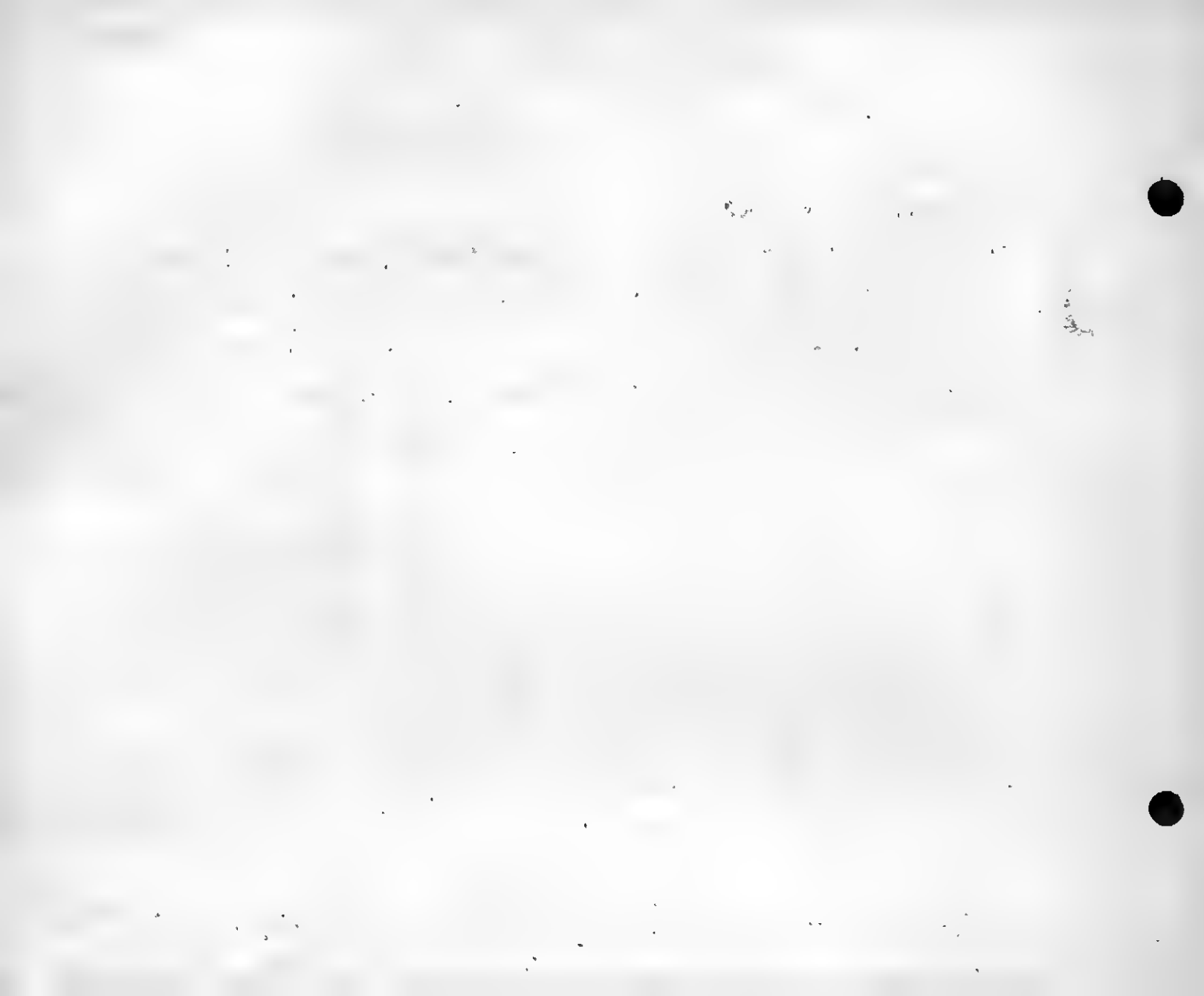
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or print)			First PAUL			Middle NEWTON			Last JONES			2a. DATE OF DEATH Month OCTOBER			Day 28			Year 1968			2b. HOUR A 12:20 M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH AUGUST 23, 1896			6. AGE (In years last birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE, Md.														
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SELF-EMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY GAS STATION														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 5922 CLAYTON AVE. #21206											
14. FATHER'S NAME First Robert			Middle Newton			Last Jones			15. MOTHER'S MAIDEN NAME First Marie			Middle Mowry			Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <input checked="" type="checkbox"/> No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 204-16-2048A			17. INFORMANT Mrs Elizabeth Jones			Address 5922 Clayton Ave. 6											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>thrombosis of the left</u> <u>anterior descending coronary artery</u> (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>coronary arteriosclerosis</u> (c) <u>coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) 4201																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY; OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town			County			State								
22a. I certify that (I) (this hospital) attended the deceased from <u>October 27, 1968</u> , to <u>October 28, 1968</u> , that (I) (we) lost saw the deceased alive on <u>October 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>Lawrence J. Misanik</i>			DEGREE M.D.			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 10-28-68														
22d. PHYSICIAN'S NAME (Type) Lawrence J. Misanik, M.D.			22e. ADDRESS 7620 York Road, Towson, Md. 21204																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-31-1968			23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery			23d. LOCATION (City or Town) Baltimore			(County) Co.			(State) Md								
24. FUNERAL DIRECTOR Lassahn Funeral Home			7401 Belair Road			25a. REC'D BY REGISTRAR OCT 30 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>														





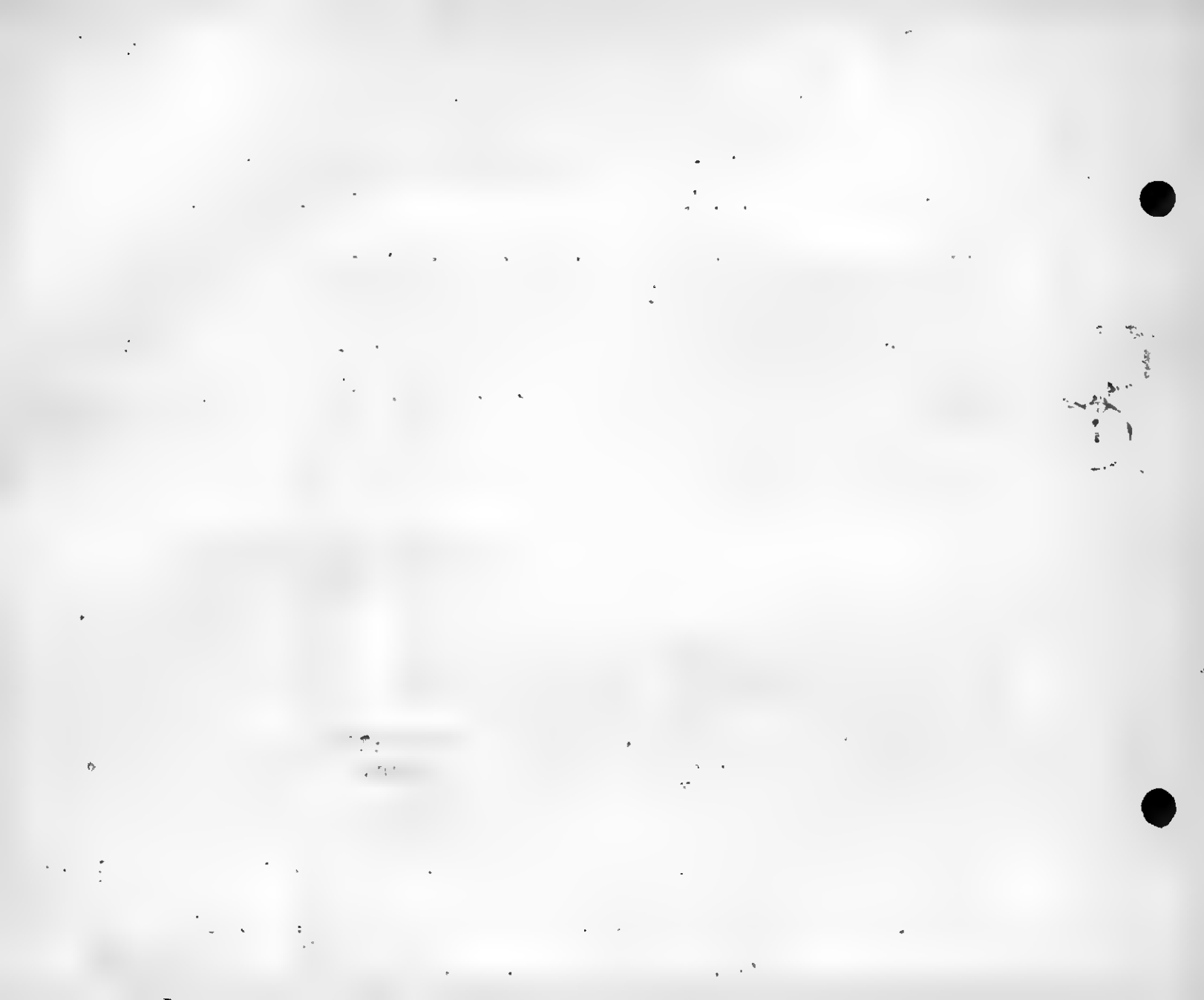




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Ida			Middle Natalie			Last Jorcyk		
2a. DATE OF DEATH			10			Month 13			Day 68		
2b. HOUR			7:15								
3 SEX Female			4 RACE White			5. DATE OF BIRTH May 8, 1894			6 AGE (In years last birthday) 74 YRS		
7a. BIRTHPLACE (State or foreign country) Penna			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County Md.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Great. Balt. Med. cen.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Perry Hall			13d. INSIDE CITY, LIM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 9104 Deborah Ave			14 FATHER'S NAME First Albert			Middle Swaihuber			Last Minnie		
15 MOTHER'S MAIDEN NAME First Malina			Middle Swaihuber			Last Minnie			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) No		
16b. SOCIAL SECURITY NO.			17 INFORMANT Mrs Helen Koch			Address Same					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli 201X DUE TO, OR AS A CONSEQUENCE OF Hodgkins Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year. P.M. 19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. 14, 1968 to Oct. 13, 1968, that (I) (we) lost saw the deceased alive on Oct. 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Abdolvahab Purnia			DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Oct. 13, 1968					
22d. PHYSICIAN'S NAME (Type) Abdolvahab Purnia			22e. ADDRESS Greater Baltimore Medical Center								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/16/68			23c. NAME OF CEMETERY OR CREMATORY Evergreen			23d. LOCATION (City or Town) (County) (State) Bell Mountain Penna		
24 FUNERAL DIRECTOR Leonard J Ruck Inc.			ADDRESS Baltimore, Md			25. FILED BY REGISTRAR OCT 14 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MARIE W. JORDAN</b>			2a. DATE OF DEATH Month <b>OCT.</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>1:18</b> PM	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 7, 1876.</b>		6. AGE (in years last birthday) <b>92</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md.	
10. CITY OR TOWN OF DEATH <b>Parkton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rt. 1, Armacost Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>Rt. 1, Armacost Road</b>							
14. FATHER'S NAME First <b>Frederick</b> Middle <b>T.</b> Last <b>Gotsch</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>Gehring</b> Last <b>Gehring</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Bertha J. Mays</b> Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute C.V. disease</b> <b>412.1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>Oct. 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/9/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. M. France</b>		22c. DATE SIGNED <b>10/19/68</b>		22d. PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>			
22e. ADDRESS <b>PARKTON, MD.</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/14/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Baltimore, Md. 21214</b>				25a. RECEIVED BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



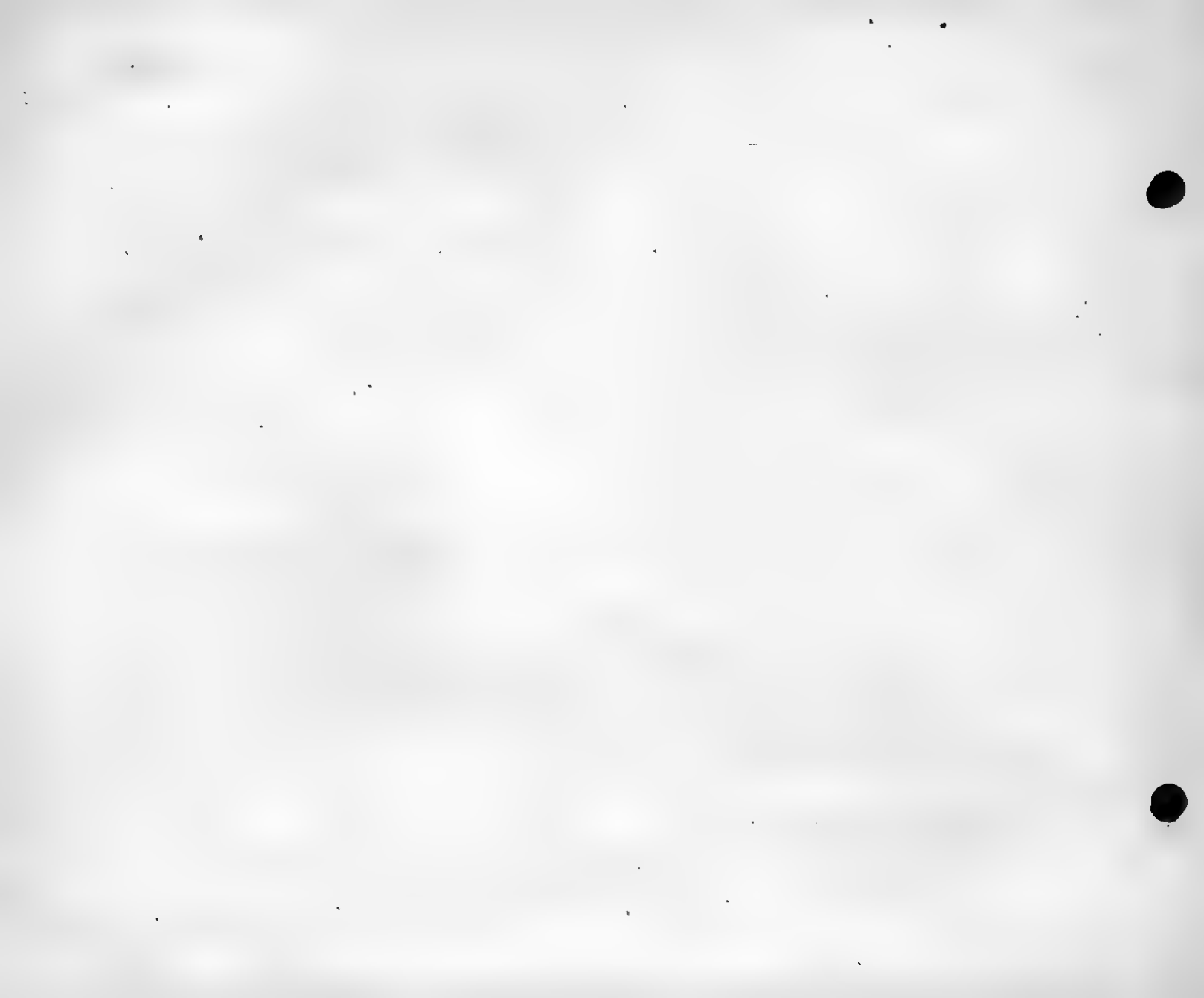
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <b>1048 Clarence L. Joyner</b>		2a DATE KNOWN OF DEATH ESTIMATED <b>October 3, 1968</b>		2b HOUR <b>11:00 AM</b>	
3 SEX <b>male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH <b>6-2-1883</b>	6 AGE (In years last birthday) <b>85</b> YRS	7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	8 IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. give street address) <b>St. Joseph's Hosp.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>self employed</b>	
13a U.S.A. RESIDENCE (Where deceased lived, if admission) STATE <b>Md.</b>		13b COUNTY <b>Baltimore</b>		13c STREET AND NUMBER <b>6635 Wycombe Way</b>	
14 FATHER'S NAME First <b>David</b> Middle <b>Joyner</b> Last <b>Joyner</b>		15 MOTHER'S MAIDEN NAME First <b>Susan</b> Middle <b>Livingston</b> Last <b>Livingston</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16b SOCIAL SECURITY NO. <b>218329583</b>		17. INFORMANT <b>Mrs Minnie E. Joyner</b>		ADDRESS <b>same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Encephalomalacia of Pons</b> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1341</b> (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yr</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>332X</b>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Family Permission</b>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>10/3/68</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>10/7/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc Baltimore, Md.</b>		ADDRESS		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
25a REC'D BY REGISTRAR <b>OCT 4 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 6 Film 11/7/68 kx  
14049

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14060

1 DECEASED NAME (Type or print) <b>JOHN F. KALB</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>68</b> Year			2b. HOUR <b>8:55 AM</b>					
3 SEX <b>M</b>		4. RACE <b>W</b>		5 DATE OF BIRTH <b>12/14/69</b>		6. AGE (In years last birthday) <b>98</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTO.</b>					
10 CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SHADY GROVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FARMER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>WOODPLAWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1001 N. ROLLING RD</b>			
14. FATHER'S NAME First Middle Last <b>DAVID KALB</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>ELIZABETH LUND</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT <b>EDGAR A. KALB</b>		Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-vascular Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7121</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		2 b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
2 d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		2.e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>58</b> , to <b>Oct.</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>October 28</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death											
22b. SIGNATURE <b>Leo J. Gaver, M.D.</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN NAME (Type)				22e. ADDRESS <b>1 Mallow Hill Ave., Baltimore, Md.</b>		22c. DATE SIGNED <b>10/30/68</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/2/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LERRAINE</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. CO. MD.</b>					
24. FUNERAL DIRECTOR <b>E.S. MALNARR</b>				ADDRESS <b>301 FREDERICK 21228</b>		25a. RECD BY REGISTRAR DATE <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR 153  
304M REV





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 4 and 5) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

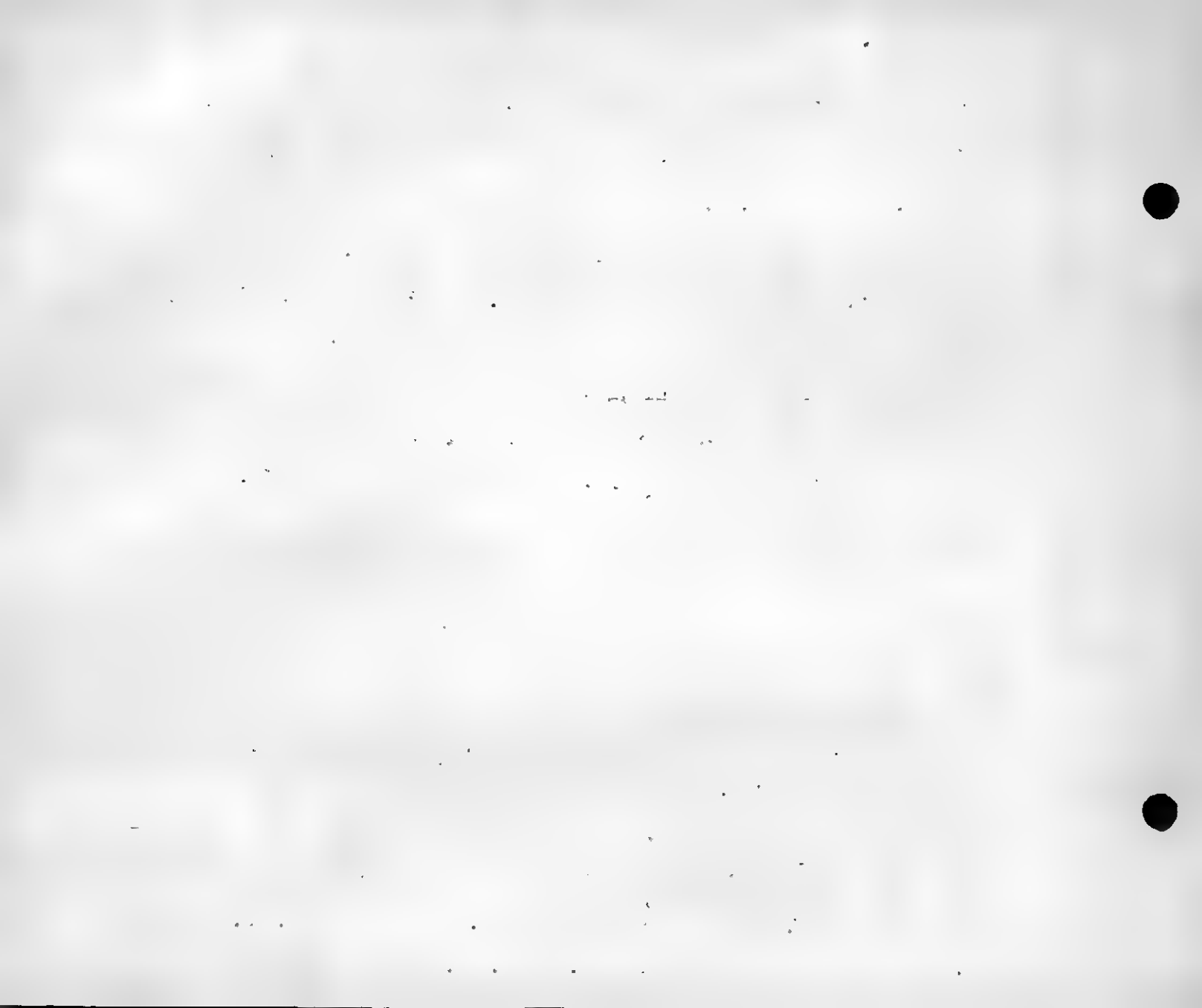
14050

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14061

1 DECEASED-NAME (Type or print) <b>Herbert L. Kattenhorn</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>1:45</b> P.M.					
3 SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Nov. 18, 1897</b>		6. AGE (in years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md					
10 CITY OR TOWN OF DEATH <b>Catonsville</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Calverton</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3437 Old Frederick Rd.</b>		
14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Army</b>		16b. SOCIAL SECURITY NO <b>220-09-2358</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bumckogenic Calcification</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1621</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>Jan. 1</b> , 19 <b>68</b> , to <b>Oct. 28</b> , 19 <b>68</b> , that <b>he</b> (we) last saw the deceased alive on <b>Oct. 28</b> , 19 <b>68</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Rafael H. Marin</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-28-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Rafael H. Marin, M.D.</b>					22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

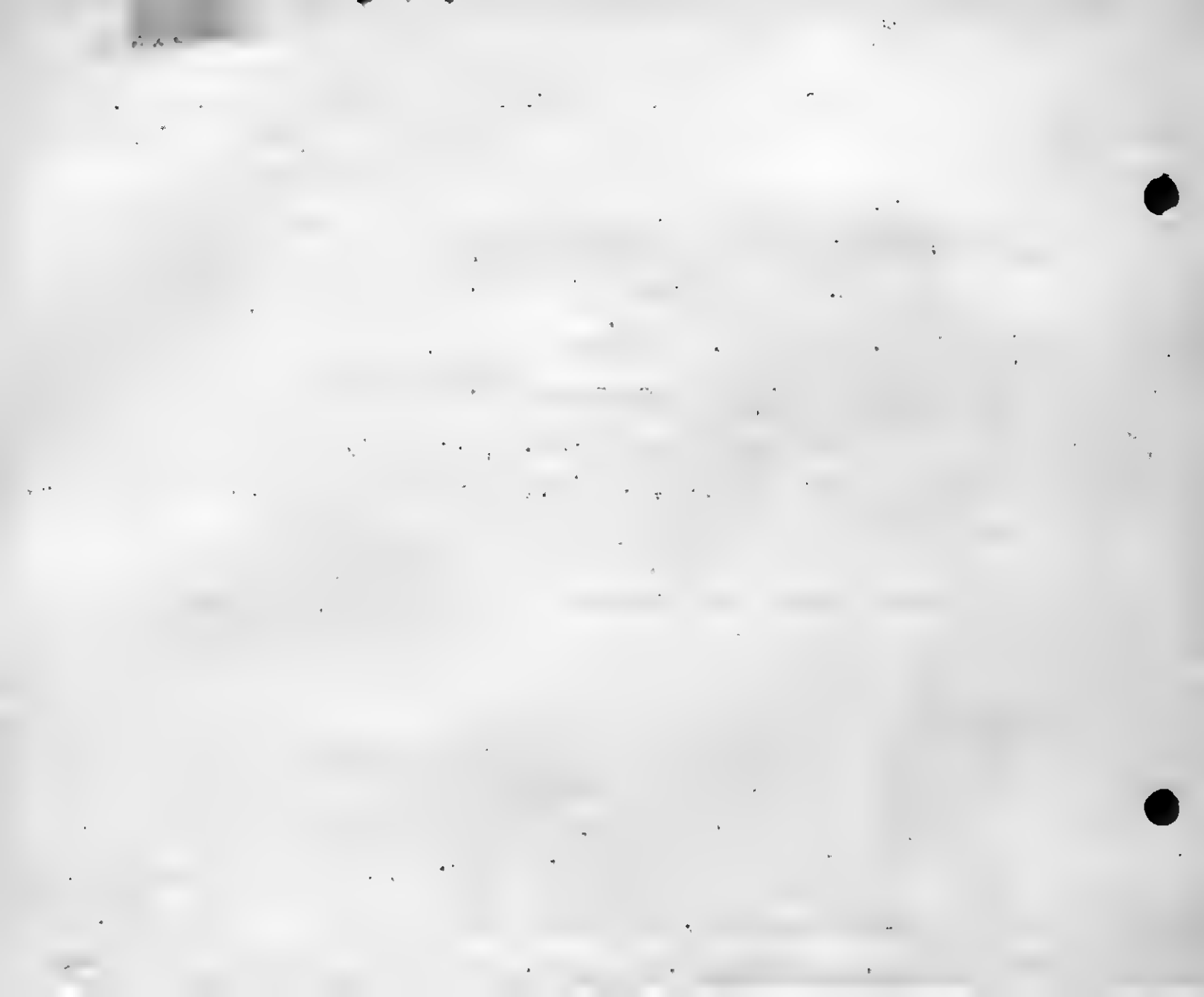


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED NAME (Type or print)			First HARRY			Middle L.			Last KELLUM			2a. DATE OF DEATH Month 10, Day 30, Year 1968			2b. HOUR 6:30 P.M.	
3 SEX Male			4 RACE White			5 DATE OF BIRTH June 10, 1889.			6 AGE (In years last birthday) 79 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.							
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines 16 Fusting Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Clerk--Dept. Education			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 7041 Eastbrook Avenue				
14 FATHER'S NAME John J.			First John			Middle J.			Last Kellum			15. MOTHER'S MAIDEN NAME Mary Griffio				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 213-10-6933			17 INFORMANT Mrs. Rosalyn McGrane			Address Same,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u>												3 wks.				
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease.</u>												10 yrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> , 1968, to <u>10-30</u> , 1968, that (I) (we) last saw the deceased alive on <u>10-28</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.																
22b. SIGNATURE <u>Wilmer K. Gallagher M.D.</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 10-31-68							
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D.			22e. ADDRESS 6209 Frederick Ave. Baltimore, Md. 21228													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11/2/68.			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS			25a. REC'D BY REGISTRAR NOV 4 1968			25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

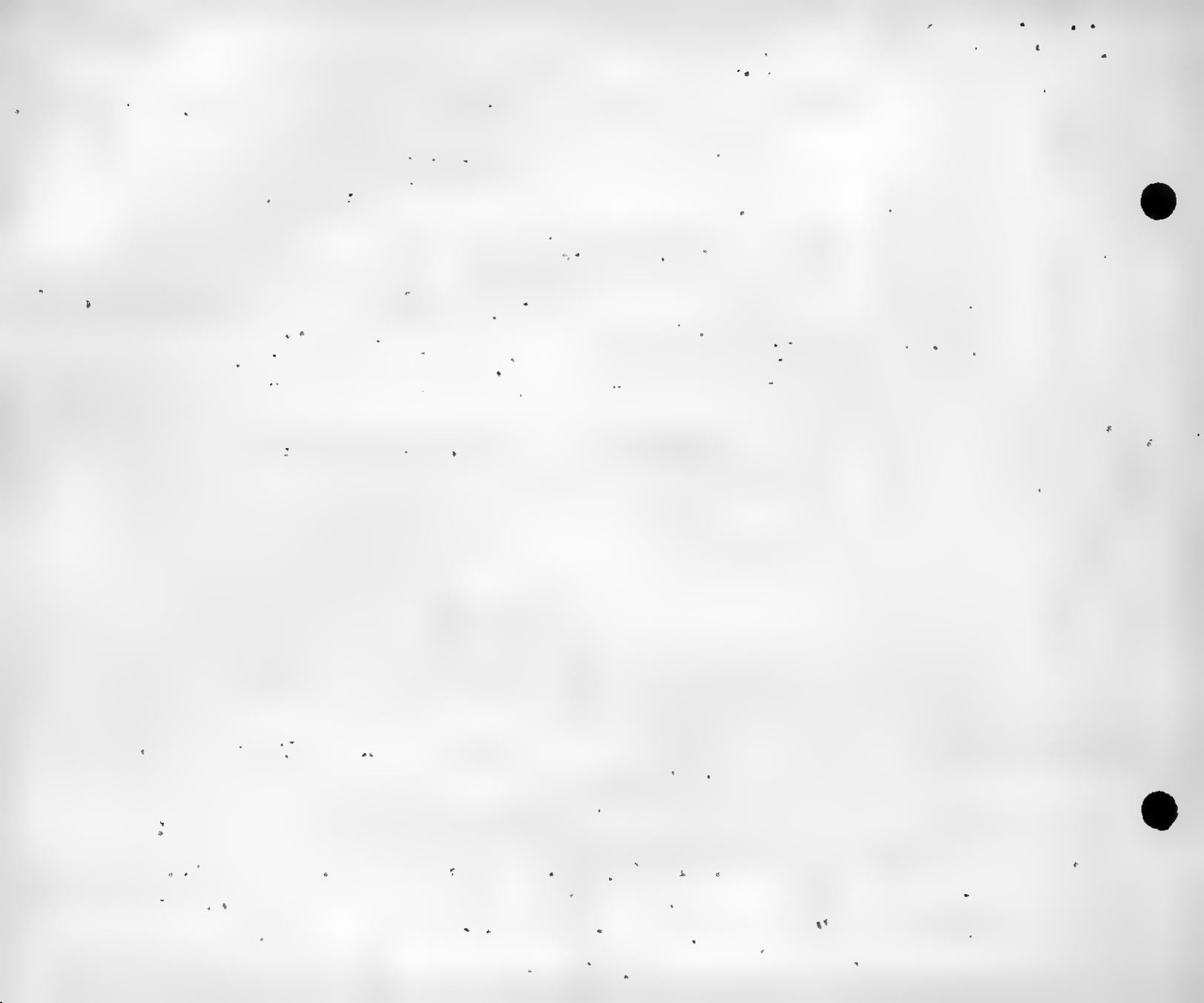
14052

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14063

1 DECEASED NAME (Type or print)		First <b>Damian</b>		Middle <b>Winfield</b>		Last <b>Kessler</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>1968</b>			2b. HOUR <b>12</b> P.M.	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>June 17, 1962</b>			6. AGE (In years last birthday) <b>6</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md						
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2820 Westfield Ave., 21214</b>				
14. FATHER'S NAME First Middle Last <b>Chas. W. Kessler</b>				15. MOTHER'S, MAIDEN NAME First Middle Last <b>Clay Haughton</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give name and date of service)		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mother</b>		Address <b>Same</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningitis due to achromobacter (Mino-Herella)</b> <b>320.8</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25/</b> , 19 <b>68</b> , to <b>10/26/</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/26/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/26/68</b>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>						
24. FUNERAL DIRECTOR <b>M. McManus</b>		ADDRESS <b>6667 Harford Rd</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



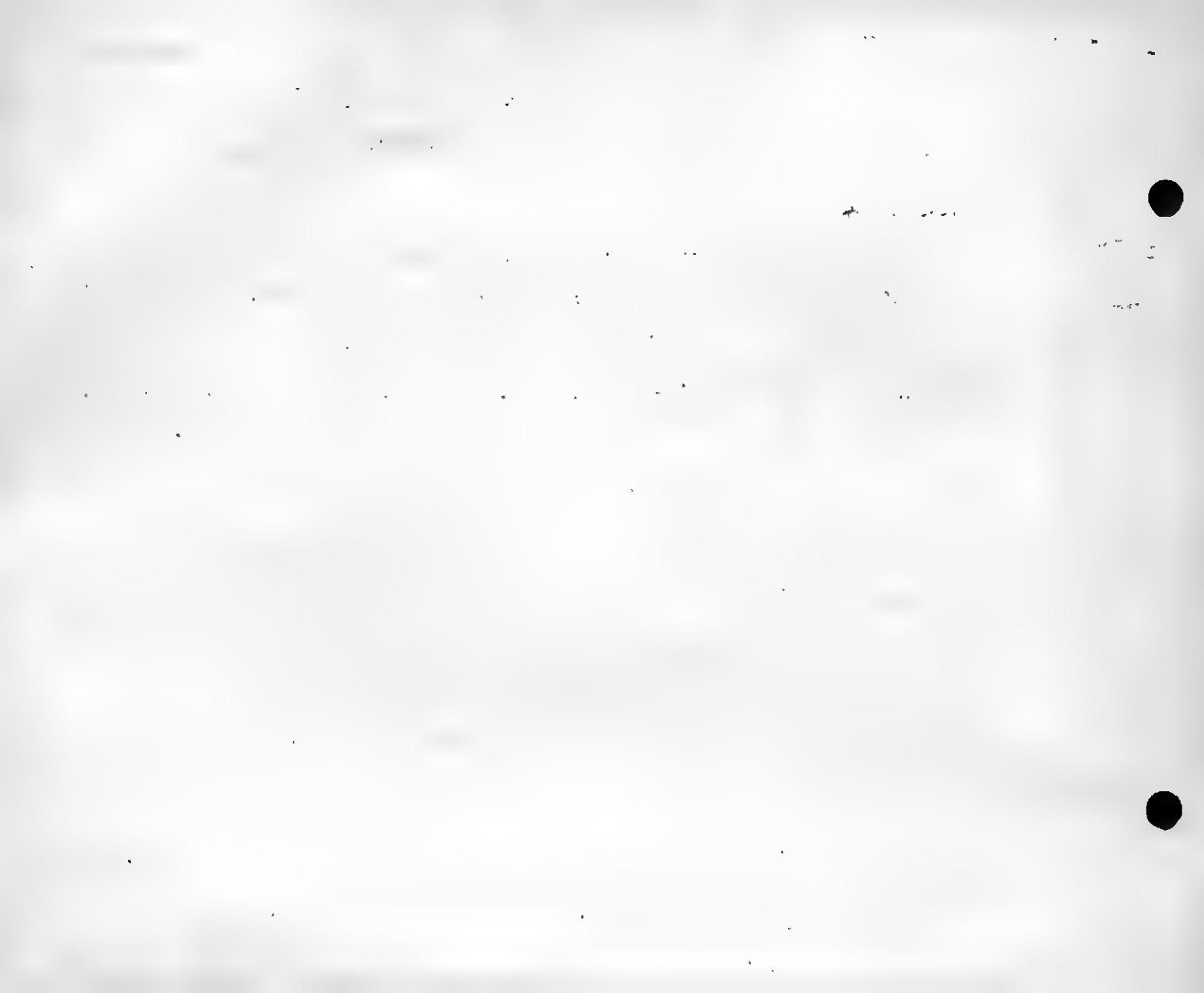
## CERTIFICATE OF DEATH

14064

1. DECEASED NAME (Type or print) <i>Belle</i>		First		Middle		Last		2a. DATE OF DEATH <i>Oct.</i> Month <i>6</i> Day <i>68</i> Year		2b. HOUR <i>9:00 A</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH		6. AGE (In years last birthday) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE</i> Md					
10. CITY OR TOWN OF DEATH <i>Baltimore Co.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MILFORD MANOR NURSING HOME</i>		12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2833 W. COLD SPRING LANE</i>			
14. FATHER'S NAME First <i>SAMUEL</i>		Middle <i>TUROW</i>		Last <i>HASSAH</i>		15. MOTHER'S MAIDEN NAME First <i>?</i>		Middle <i>?</i>		Last <i>?</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-01-07121</i>		17. INFORMANT Address <i>MRS. CHARLOTTE KAUFMAN, 5701 STUART AVE. #2121</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>411 -</i> IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Hypertension + Arteriosclerotic Cardiovascular Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Left hemiplegia</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , 19 to <i>10/6/68</i> , 19, that (I) (we) last saw the deceased alive on <i>10/5/68</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Louis R. Maser M.D.</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <i>LOUIS R. MASER M.D.</i>		22e. ADDRESS <i>2724 SMITH AVE BALTIMORE MD 21209</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>10-9-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OHEL YAKOV</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE, MARYLAND</i>					
24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>OCT 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



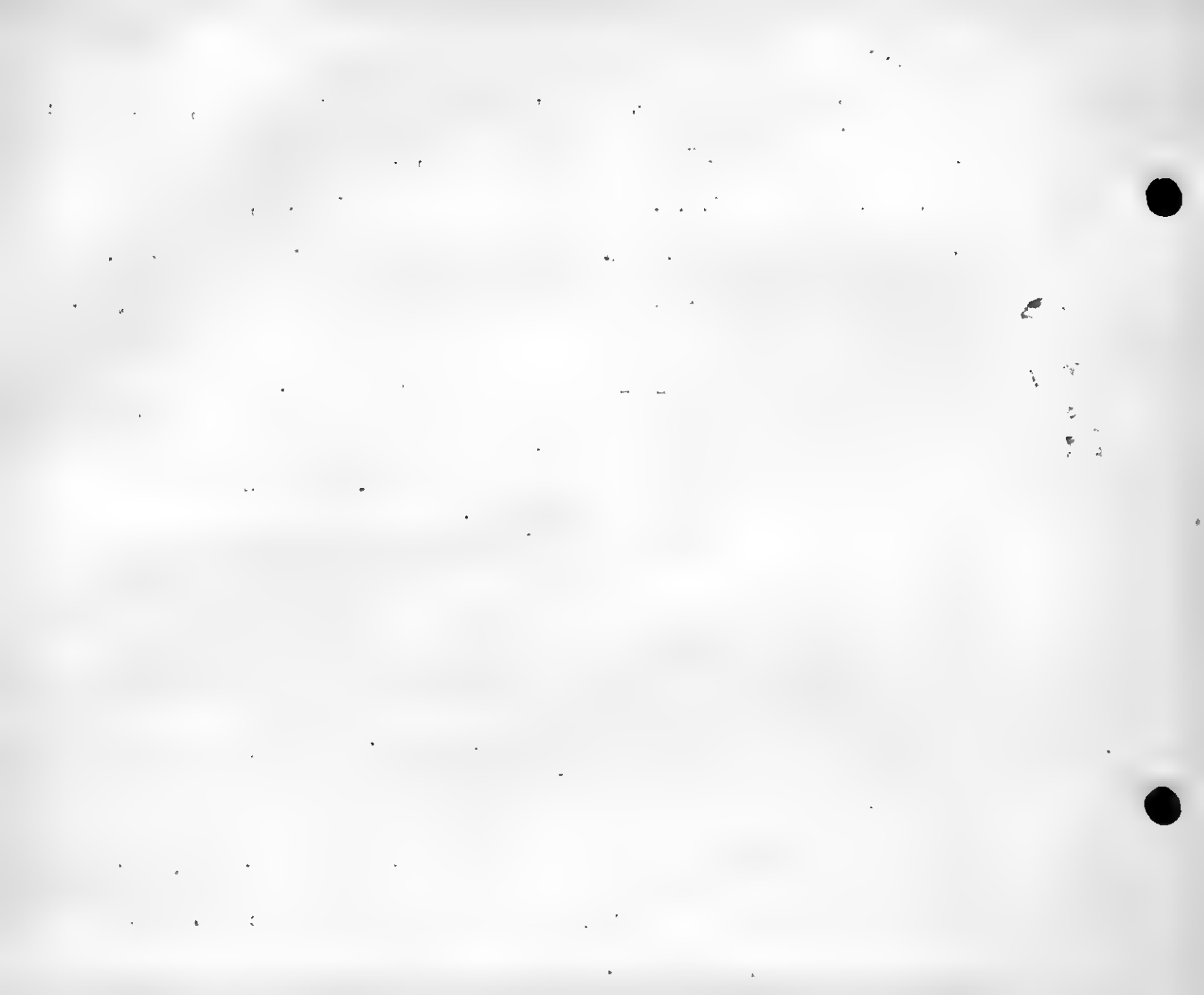


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
MARIE			D.		KIRCHENBAUER				OCTOBER Month 22, Day 1968 Year		
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR		
FEMALE		WHITE		MAY 31, 1911			57 YRS.		2:20 A		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
NEW JERSEY		U.S.A.				BALTIMORE, Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL			Sales Lady			DEPT. STORE		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			BALTIMORE						8425 E OLD HARFORD RD. #34		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
			DonDero				Clara		Dougherty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO			215-07-0773		Mr Forrest S Kirchenbauer			Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>rupture of myocardium sec. to acute myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>thrombosis rt. coronary artery</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
White <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (I) (this hospital) attended the deceased from <u>October 19, 1968</u> , to <u>October 22, 1968</u> , that (I) (we) last saw the deceased alive on <u>October 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>J. Cilliani</u>											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Ines Cilliani, M.D.		7620 York Rd. & Towson, Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		10/24/68		Parkwood		Baltimore, Maryland					
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore, Maryland						OCT 23 1968		<u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV. 7-68

14053

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14066  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last WALTER E. KNAPP			2a. DATE OF DEATH 10 Month 16 Day 68 Year		2b. HOUR 8-15 P.M.
3 SEX M	4. RACE W	5. DATE OF BIRTH 5/30/1884		6 AGE (In years lost birthday) 84 YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) PENNA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO. Md.	
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHADY NOOK HOME		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RAILROAD	
13a. USUAL RESIDENCE (Where deceased admission) STATE MD		13b. COUNTY BALTO	13c CITY OR TOWN CATONSVILLE	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 310 Thackeray Ave.
14 FATHER'S NAME First Middle Last John T. KNAPP		15 MOTHER'S MA DEN NAME First Middle Last ? Knoby		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) No	
16b SOCIAL SECURITY NO		17 INFORMANT Address MRS. Ruby KNAPP 310 Thackeray Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>with chronic failure</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs +
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) L					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 2, 1956</u> , to <u>Oct. 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct. 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John A. Nesbitt, Jr.				22c. DATE SIGNED 10-17-68	
22d. PHYSICIAN'S NAME (Type) John A. Nesbitt, Jr., M.D.				22e ADDRESS 1009 Frederick Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 10/19/68		23c NAME OF CEMETERY OR CREMATORY LORRAINE CEM.	
23d LOCATION (City or Town) (County) (State) BALTO. Md		23e REC'D BY REGISTRAR DATE OCT 21 1968			
24 FUNERAL DIRECTOR E. S. MacNabb		25b. REGISTRAR'S SIGNATURE John A. Nesbitt, Jr.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

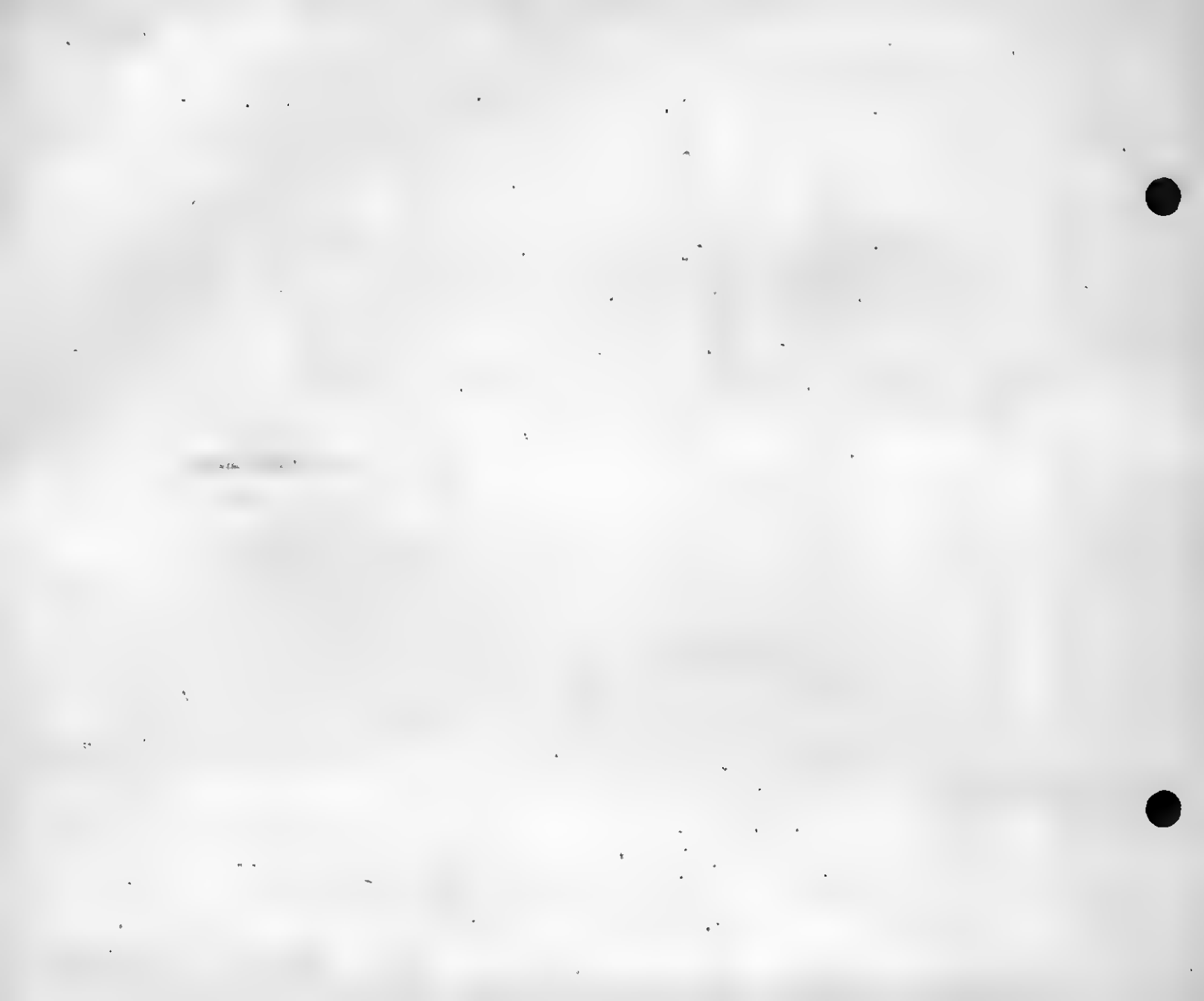
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

14056

14067

1 DECEASED-NAME (Type or print) <b>Owen C. Knauff</b>			2a DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>68</b>			2b HOUR M <b>10</b>			
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 21, 1904</b>		6. AGE (In years last birthday) <b>64</b> YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1509 Clearwood Rd</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1509 Clearwood Rd</b>	
14. FATHER'S NAME First Middle Last <b>Francis I. Knauff</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Briget Bannagan</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>Yes 1919-1920</b>		16b. SOCIAL SECURITY NO <b>214-01-9360</b>		17. INFORMANT <b>Mrs Anna B Knauff</b>		Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Chronic Lymphatic Leukemia</b> <b>2041</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 1/2 months</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>204</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>68</b> , to <b>Oct 29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept 29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Bernard S. Karpers Jr.</b>				DEGREE <b>PHYS.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct 29, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>BERNARD S. KARPERS, JR</b>				22e. ADDRESS <b>514 MEDICAL ARTS BLDG.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/2/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Leona rd J Ruck Inc</b>				ADDRESS <b>Baltimore, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNC. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14057

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14068

1 DECEASED NAME (Type or Print) <b>KERMIT</b>			First <b>G.</b>			Middle <b>KNIGHT</b>			Last			2a DATE KNOWN <input checked="" type="checkbox"/> OF EST. DEATH MATED <input type="checkbox"/> Month <b>10</b> Day <b>20</b> Year <b>1968</b>			2b HOUR <b>M</b>														
3 SEX <b>Male</b>			4 RACE <b>Colored</b>			5 DATE OF BIRTH <b>1-13-50</b>			6 AGE (In years last birthday) <b>18</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>			2c. DATE PRONOUNCED DEAD Month <b>October</b> Day <b>20</b> Year <b>1968</b>			2d HOUR <b>8:30</b> AM <b>A.</b>								
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>						7b. CITIZEN OF WHAT COUNTRY?						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH <b>BALTIMORE</b>											
10 CITY OR TOWN OF DEATH <b>TOWSON</b>						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Expressway Ruxton Road Overpass</b>						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)						12b. KIND OF BUSINESS OR INDUSTRY											
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>						13b COUNTY <b>Baltimore</b>						13c CITY OR TOWN <b>Baltimore</b>						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13e. STREET AND NUMBER <b>2817 W. North Avenue</b>					
14 FATHER'S NAME <b>Charles Knight</b>						First <b>Charles</b> Middle <b>Knight</b> Last						15 MOTHER'S MAIDEN NAME <b>Mildred Foster</b>						First <b>Mildred</b> Middle <b>Foster</b> Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						(If yes give war or dates of service)						16b SOCIAL SECURITY NO.						17 INFORMANT <b>Mildred Knight</b> ADDRESS <b>2817 W. North</b>											
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>815.03</b> <b>Multiple severe injuries</b>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple severe injuries</b>																													
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2194</b>																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day Year <b>7:40 AM 10-20 1968</b>						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Driver in auto-fixed object collision</b>																	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Expressway</b>						21f LOCATION Street or R.F.D. No. <b>Ruxton Road Overpass</b> City or Town <b>Baltimore</b> County <b>Baltimore</b> State <b>Md.</b>																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <b>Charles S. Springate</b>						M.D. <b>Charles S. Springate, M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>																	
EXAMINER'S NAME (Type)												ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
												DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																	
												ADDRESS (Street, city, town, or county)																	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b DATE <b>10-24-68</b>						23c NAME OF CEMETERY OR CREMATORY <b>Ashburton Memorial</b>																	
												23d LOCATION (City or Town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>																	
24. FUNERAL DIRECTOR <b>Wilmington S. Phillips</b>						ADDRESS <b>172 W. Mount</b>						25a REC'D BY REGISTRAR <b>OCT 24 1968</b>																	
												25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

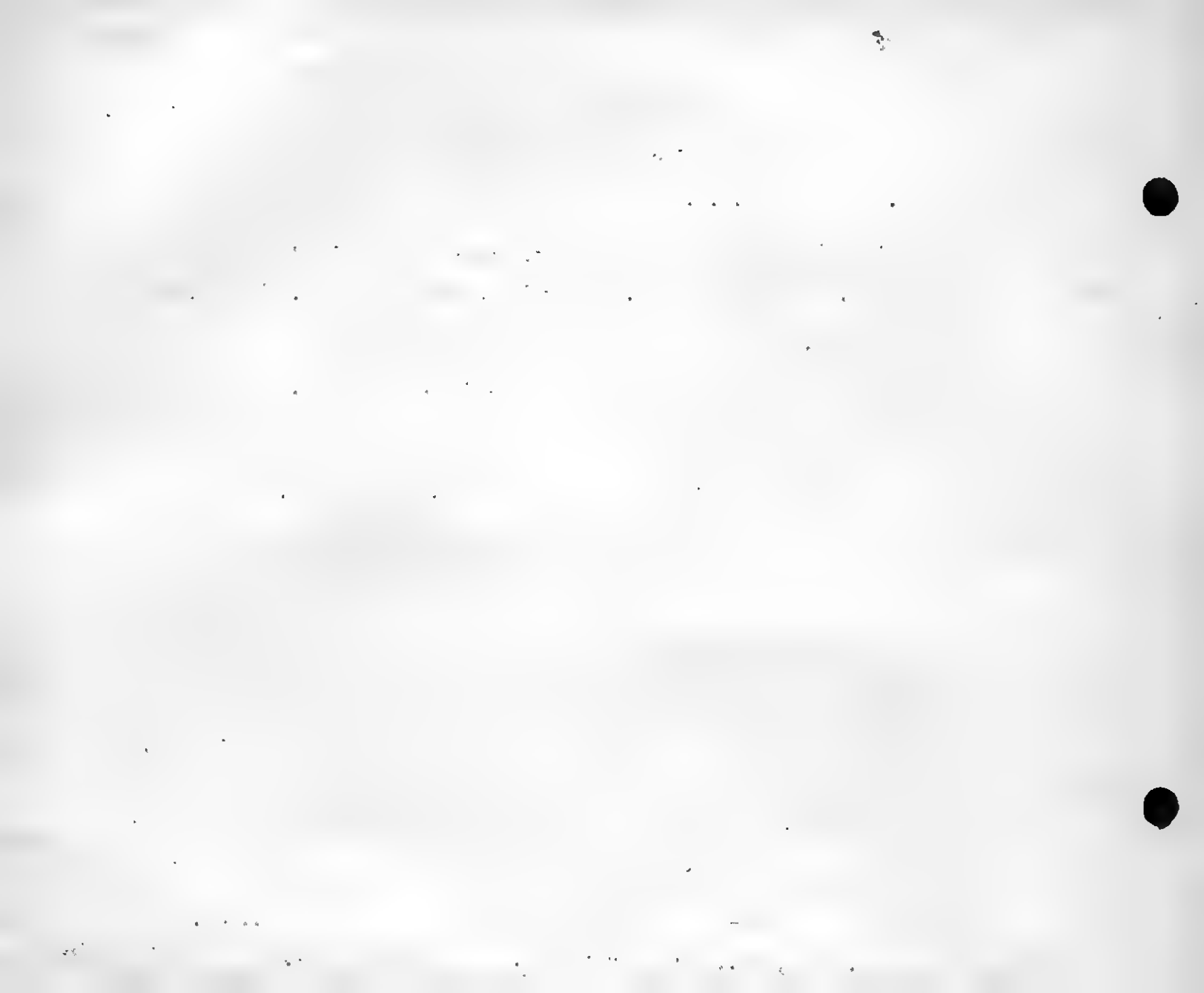
14058

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14069

1 DECEASED-NAME (Type or print)		First MARY	Middle CATHERINE	Last LACHER	2a. DATE OF DEATH Month 10 Day 26 Year 1968		2b. HOUR 9:00a M
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 8/23/1899		6 AGE (in years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Rt. 15, Box 692		13f. Middle River					
14. FATHER'S NAME First Middle Last Robert E. Ward				15 MOTHER'S MAIDEN NAME First Middle Last Mary Gullery			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Albert V. Lacher, Sr., Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 1129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease with DUE TO, OR AS A CONSEQUENCE OF (c) old myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9/10, 1968, to 10/26, 1968, that (I) (we) last saw the deceased alive on 10/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles C. Brown, M.D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/26/68	
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.		22e. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-30-68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.				25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14053

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14070

1. DECEASED-NAME (Type or print) First Middle Last JANE S. LAIRD			2a. DATE OF DEATH 10-30-68 Month Day Year			2b. HOUR 2 A M					
3 SEX FEMALE		4. RACE CAU		5. DATE OF BIRTH 9-28-16		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MINS.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.					
10 CITY OR TOWN OF DEATH BALTIMORE, MD.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN LUTHERVILLE		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 405 FOX CHAPEL DRIVE			
14. FATHER'S NAME First Middle Last Joseph W. Small, Jr.			15. MOTHER'S MAIDEN NAME First Middle Last Sara Shenefelt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No None			16b. SOCIAL SECURITY NO None		17. INFORMANT Family information			Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) OSTEOLYTIC & OSTEOLASTIC METASTASES 114X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) IN THE PROXIMAL FEMUR WITH SEVERE ANEMIA DUE TO, OR AS A CONSEQUENCE OF (c) BREAST CARCINOMA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 172X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-06-68, 19 to 10-30, 1968, that (I) (we) last saw the deceased alive on 10-30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. F. Naeim				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-30-68			
22d. PHYSICIAN'S NAME (Type) DR. F. NAEIM				22e. ADDRESS GBMC 6701 N. CHARLES ST.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.					
24. FUNERAL DIRECTOR John Brown Lewis		ADDRESS Lawson, Md.		25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



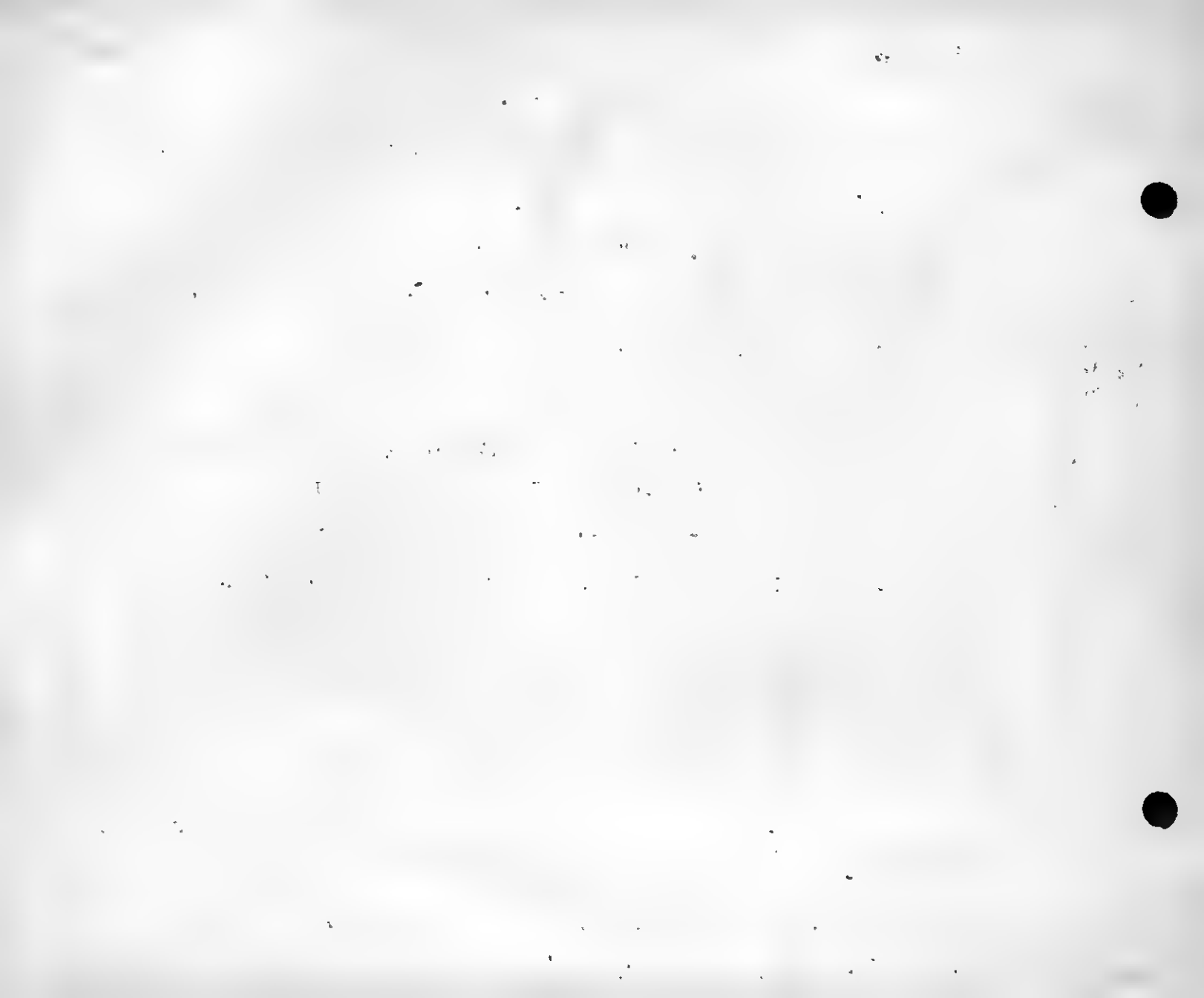
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514  
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14050 CERTIFICATE OF DEATH 14071									
1. DECEASED-NAME (Type or print)			First MARGARET Middle LOUISE Last LAMBERT			2a. DATE OF DEATH OCT. Month 1 Day 68 Year		2b. HOUR 8:15	
3 SEX FEMALE		4 RACE White		5. DATE OF BIRTH JANUARY 17, 1916		6. AGE (In years last birthday) 52 YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GR. BALTO. MED. CENTER		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b COUNTY		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2620 Hampden Ave.	
14. FATHER'S NAME First Edward Middle L Last Bigham			15. MOTHER'S MAIDEN NAME First Alice Middle MANN Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT Elizabeth L. Fisher Address 2960 Warwick Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1602 CACKERIA & MALNUTRITION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARCINOMA OF MAXILLARY SINUS WITH DUE TO, OR AS A CONSEQUENCE OF (c) METASTASIS TO LUMBO VERTEBRA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RHEUMATIC HEART DISEASE WITH MITRAL COMMISSURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from AUG. 20, 1968, to OCT. 1, 1968, that (I) (we) last saw the deceased alive on OCT. 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Y. JOE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-1-68			
22d. PHYSICIAN'S NAME (Type) Y. JOE		22e. ADDRESS 6701 N. CHARLES STREET							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE October 4, 1968		23c NAME OF CEMETERY OR CREMATORY Parkwood		23d LOCATION (City or Town) Baltimore		(County) (State) Md	
24 FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS 3631 Falls Rd		25a. REC'D BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14062

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14072

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR					
Gluseppa Sansone Lanasa						October 21 1968			9 PM								
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR			
F		W		9/12/1877		91 YRS						October 21 1968		9 PM			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
Italy				U.S.A.								Baltimore Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Towson				St. Joseph's Hospital				Homemaker				Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.								Baltimore						5003 Greenleaf Road			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last								
A. Sansone						Anna Catarnzro											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT				ADDRESS					
No				217-32-8363A				Miss Anna J. Lanasa				(Same)					
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> 884X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <u>Generalized Arteriosclerosis and Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fractured Hip</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
												4 Days					
												10 yrs					
												3 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
701.																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
7/17/68				Fractured Hip				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				7/15/68 PM				Slide off chair in Home.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State									
				Home													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED									
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				10/31/68									
Charles F. O'Donnell, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				10/25/68				New Cathedral				Baltimore Md.					
24. FUNERAL DIRECTOR ADDRESS								25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.								OCT 22 1968		Charles J. Juge							



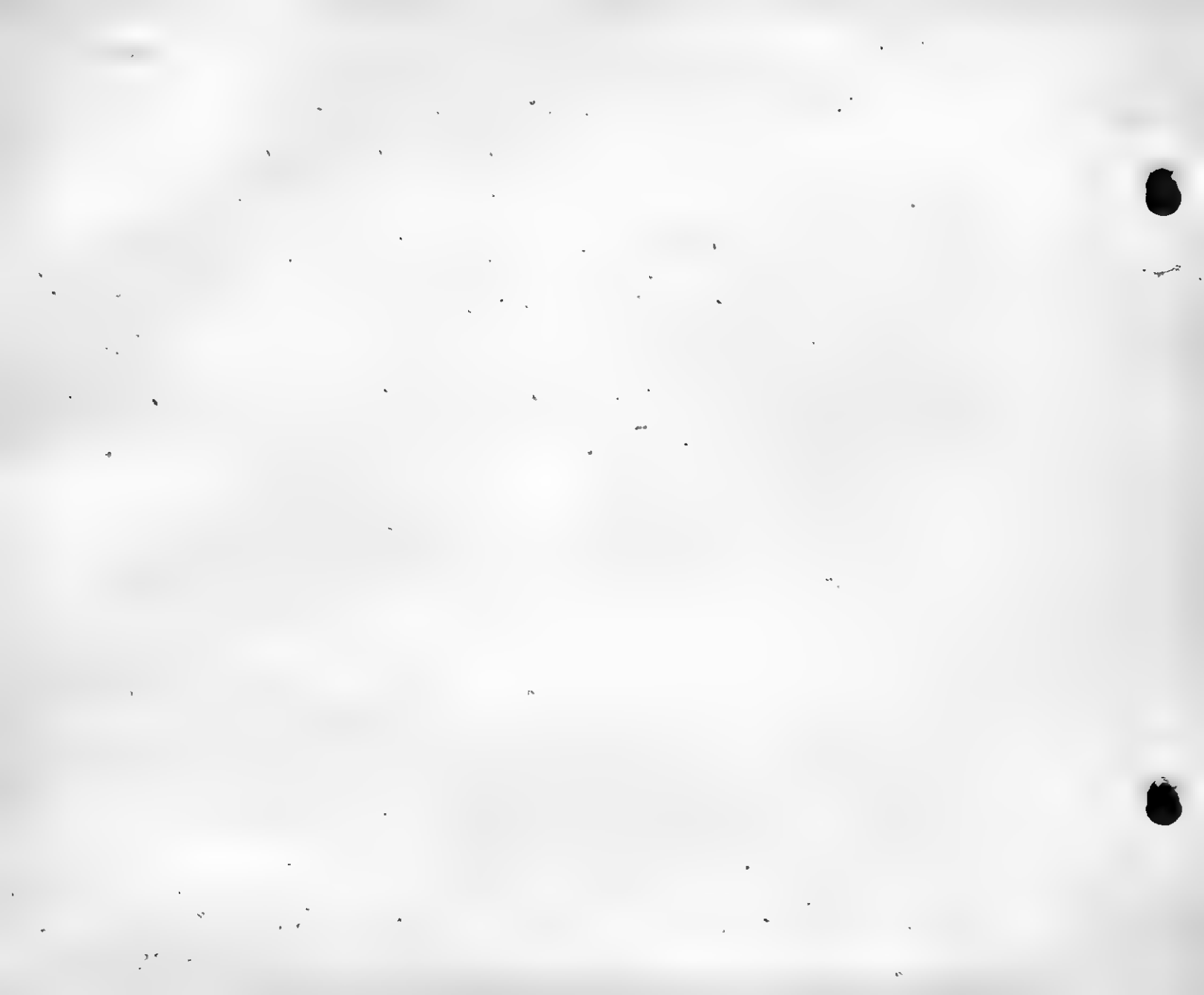


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 11-68

14068		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		14073	
1 DECEASED-NAME (Type or print) <i>Clyde Chittard Larrimore</i>				2a. DATE OF DEATH <i>Oct</i> Month <i>1</i> Day <i>1968</i> Year		2b. HOUR <i>8:10 A</i>	
3 SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>July 19, 1874</i>		6. AGE (In years last birthday) <i>94</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Pikesville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Robbs Nursing Home, Pikesville, Md.</i>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) <i>Partner M.F. Hamber</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Stevenson, Md.</i>		13d. INS-DE CITY LIM TST <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME First <i>Edward</i> Middle <i>WARRIMORE</i> Last <i>WARRIMORE</i>		15. MOTHER'S MAIDEN NAME First <i>unfrown</i> Middle <i>Stevenson, Md.</i> Last <i>Stevenson, Md.</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212-32-0119</i>	
17 INFORMANT <i>Mr. Alfred Norman Larrimore, Hillside Dr.</i>		Address <i>Stevenson, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>ASC.V.D.</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
<i>B.P.H.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3 August, 1950</i> , to <i>1 Oct 1968</i> , that (I) (we) last saw the deceased alive on <i>15 Sept 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles H. Williams</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>Charles H. Williams, M.D.</i>				22e. ADDRESS <i>Pikesville, 21208, Md.</i>			
23a. BURIAL, CREMAT. OR REMOVAL (Specify)		23b. DATE <i>Oct. 4, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Stone Chapel Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Balto., Md.</i>	
24 FUNERAL DIRECTOR <i>Frank H. Newell, Pikesville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
				DATE <i>OCT 2 1968</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-64  
3044 REV 1-65

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Francis W Lawrence Jr					Oct 26 68			6:45 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Male	Caucasion		7-29-1899		79 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md	Balt. City				Balt Co. Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Balt Co. Randallstown	Balt. Co. Gen. Hosp		Railroad		Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		Baltimore		Baltimore			5531 Bosworth Ave		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Francis W Lawrence Sr					Anne - Appleby				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes		WWI		17-09-85034 Mrs Edith Moran		Baltimore, Md.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE LUNG DISEASE 491X DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC BRONCHITIS AND EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 10/10, 1968, to 10/26, 1968, that (I) (we) last saw the deceased alive on 10/25/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Reve P. de la Santes					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/26/68		
22d. PHYSICIAN'S NAME (Type) Reve P de la Santes					22e. ADDRESS Randallstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		10-28-68		Woodtown		Baltimore			Md.
24. FUNERAL DIRECTOR Harry W Naight					ADDRESS Lyscove, Md.		25a. REC'D BY REGISTRAR OCT 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14066

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14075

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR
JERRY			MIAN	LEE	10-20-68		7:55 AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE, in years (last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
M	BLACK	7-12-15	53 YRS			10 Day 20 1968	8:00 AM
7a BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
		W.S.A.			BALTIMORE Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INST. TUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Sparrows Pt. Md.		Beth Steel Disp Br Lark Hefler		Steel			
13a USUAL RESIDENCE (Where deceased lived, if inst. tution, Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
MD.		BALT.				1552 MCKEAN AVE 3127	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
GEORGE W. LEE Sr.					SARAH BRACKENS		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
NO		246-05-0605		ADDIE HAMPKINS REIDSVILLE, N.C.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V-Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		None					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10/20/68	
M.B. DAVIS MD-6800				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10/20/68	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		10/24/68	CARVER MOUNTAIN		MURKIN MD		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Marshall Phillips		685 N. G. ... St		OCT 22 1968		Charles J. ...	

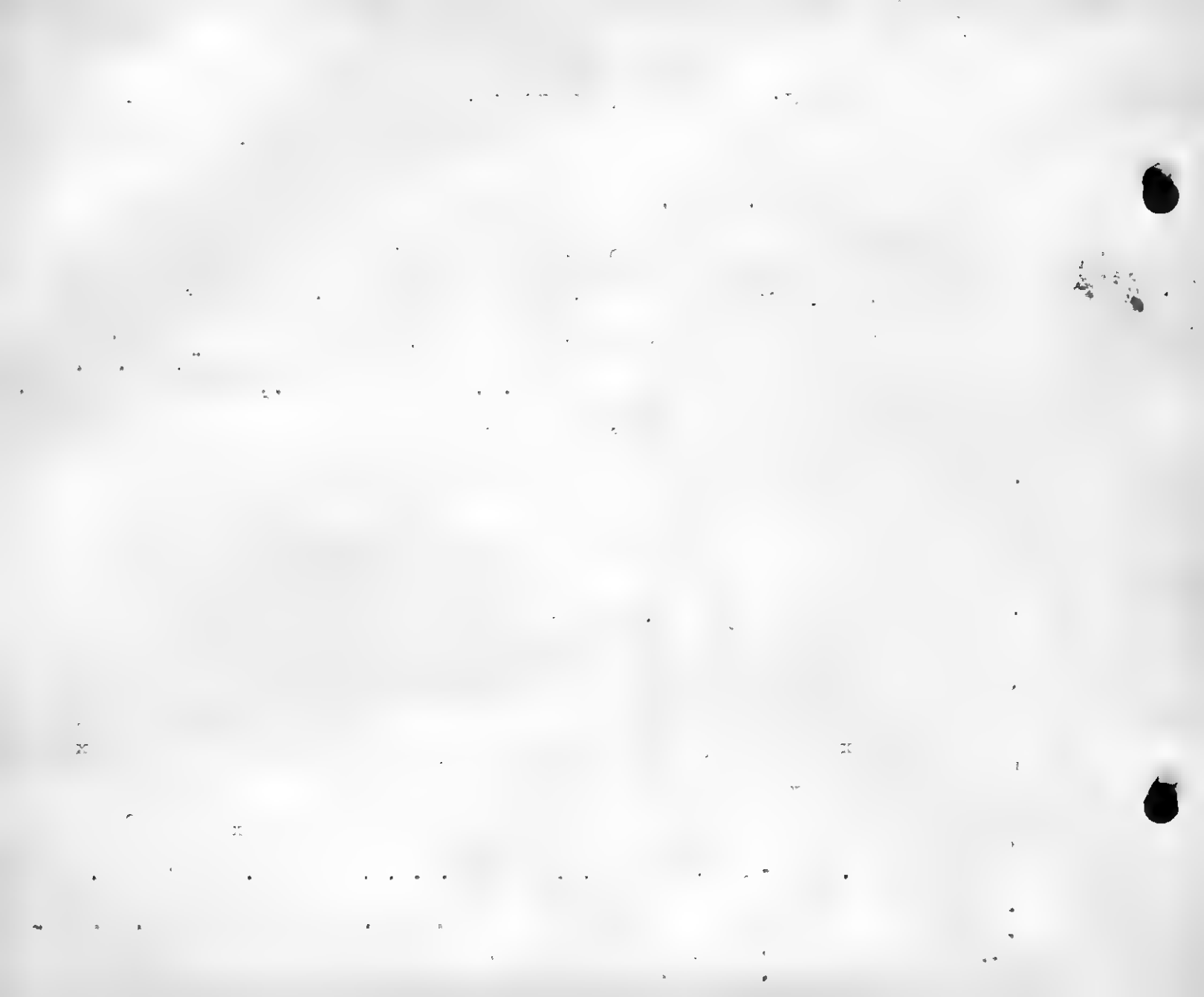


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M.E. notified - released as none Med.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 1 per tele. cert. filed 10/21/68									
14065									
14076									
1. DECEASED-NAME (Type or print) <b>WILLIAM</b>				First Middle Last <b>F. LEINWEBER, SR.</b>		2a. DATE OF DEATH Month Day Year <b>10 20 1968</b>		2b. HOUR <b>7:30aM</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH <b>09 01 1895</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HDQRS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		Md.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC, Towson, Md.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Proprietor-Contractor Heating</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>204 E. Joppa Road</b>	
14. FATHER'S NAME First Middle Last <b>F Leineweber</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret White</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Greenville, S. C. 29601 Wm. F. Leineweber, Jr., 62 Woodvale Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Ruptured Abdominal Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION <b>10-20-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aneurysm Ruptured Abdominal</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from <b>10-19</b> , 19 <b>68</b> , to <b>10-20</b> , 19 <b>68</b> , that (we) last saw the deceased alive on <b>10-20</b> , 19 <b>68</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. Eduardo Canilang M.D.</i>		22c. DATE SIGNED <b>10-20-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Dr. Eduardo Canilang M.D.</b>		22e. ADDRESS <b>G.B.M.C. 6701 N. Charles St. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Grds.</b>		23d. LOCATION (City or Town) (County) (State) <b>Timonium, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				25a. REC'D BY REGISTRAR <b>4905 York Rd. Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>		DATE <b>OCT 21 1968</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14066

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14077

1. DECEASED-NAME (Type or print) <b>CARL L LESCALLEET</b>			2a. DATE OF DEATH <b>10</b> Month <b>17</b> Day <b>68</b> Year		2b. HOUR P <b>2:50</b> M
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Aug. 9, 1890</b>		6. AGE (in years last birthday) <b>78</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CEN.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer-retired</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. CITY OR TOWN <b>Washington</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET AND NUMBER <b>Route 2</b>		
14. FATHER'S NAME First Middle Last <b>George L. Lescalleet</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>Jennie Bair</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. <b>216-14-5359</b>	17. INFORMANT Address <b>Mrs. Margaret A. Stambaugh West, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST FOLLOWED BY CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO VASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>AN ACUTE MYOCARDIAL INFARCTION WITH ARRHYTHMIA &amp;</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HYPERTENSION</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/14</b> , 19 <b>68</b> to <b>10/17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/17</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gihan Tennekoon</b>				22c. DATE SIGNED <b>10-17-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>GIHAN TENNEKOON, M.D.</b>				22e. ADDRESS <b>6701 N CHARLES ST BALT, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/19/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Taylorville</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll Md</b>	
24. FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2110. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14078
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)		First Mary		Middle H.		Last Liming		2a. DATE KNOWN OF DEATH Month Day Year 10-20-19		2b. HOUR 3A. M
3 SEX Female	4 RACE White	5 DATE OF BIRTH May 19, 1903		6 AGE (in years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year October 20 19 68	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				2d. HOUR 10A. M
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7006 Morningside Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7006 Morningside Road		
14. FATHER'S NAME First Middle Last Michael J. Reigle		15. MOTHER'S MAIDEN NAME First Middle Last Lucy Herman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If give year or dates of service) 419-20-4546		17. INFORMANT (Sister) Mrs. Helen Leftwich, 7006 Morningside Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C-V-DISEASE</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4221 Chronic Nephritis &amp; Left Nephrectomy</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION-Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>M.B. Davis</u>		EXAMINER'S NAME (Type) Melvin B. Davis		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Road		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Oct. 21, 1968
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/23/68		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Hanover, Penna.		24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REG. STRAR DATE OCT 24 1968
						25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
30M REV 1-68

14068

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14079

1. DECEASED-NAME (Type or print) <b>ARTHUR</b>		First <b>W.</b>	Middle	Last <b>LINCK</b>	2a. DATE OF DEATH Month <b>October</b> Day <b>26</b> , 1968 Year		2b. HOUR <b>4:30</b> A.M.		
3. SEX <b>Male</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 7, 1895</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md			
10. CITY OR TOWN OF DEATH <b>Lansdowne</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>339 - 5th Avenue</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Butcher</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lansdowne</b>		13d. INSIDE CITY, Y.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>339 - 5th Avenue</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>J.</b> Last <b>Linck</b>			15. MOTHER'S MAIDEN NAME First <b>Amelia</b> Middle <b>Wagner</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>217-01-0270</b>		17 INFORMANT <b>Mrs. Margaret E. Linck, 339 5th Avenue 21227</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u> DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATE THE UNDERLYING CAUSE LAST. (b) <u>with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DOX</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>67</u> , to <u>10/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death									
22b. SIGNATURE <u>Herbert J. Levickas</u> M.D.		22c. DATE SIGNED <u>10/26/68</u>		22d. PHYSICIAN'S NAME (Type) <b>Dr. Herbert J. Levickas</b>					
22e. ADDRESS <b>5404 East Drive, Baltimore, Md. 21227</b>									
23a. BURIAL, CREMATION, BURNING (Specify) <b>BURIAL</b>		23b. DATE <b>10-29-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
DECEASED-NAME (Type or print) <i>Minnie E. Linde</i>			2a. DATE OF DEATH 10 Month 29 Day 68 Year			2b. HOUR 12:15 A M			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>3/23/85</i>		6. AGE (in years last birthday) <i>83</i> YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>GERMANY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md			
10. CITY OR TOWN OF DEATH <i>Baltimore 21228</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>HOWARD</i>		13c. CITY OR TOWN <i>ELLCOTT CITY</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>BOWNE LYNCH RD</i>	
14. FATHER'S NAME <i>KARL WENDELER</i>			15. MOTHER'S MAIDEN NAME <i>DRAUDE</i>			21228			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT <i>RUDOLPH LINDE - 111 Hillside Rd -</i>					
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Urinary Bladder</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastasis see to above</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>five previous clots</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 mo</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>8-22</i> , 19 <i>68</i> , to <i>Oct 29</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>10-26</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Manuel R. Rodriguez</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10-29-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>MANUEL R. RODRIGUEZ MD</i>				22e. ADDRESS <i>1424 Sulphur Springs Rd Baltimore</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>10/31/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LERRANE</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTO. CO. MD</i>			
24. FUNERAL DIRECTOR <i>MACNAB &amp; SON</i>				ADDRESS <i>21228</i>		25a. REC'D BY REGISTRAR <i>NOV 1 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

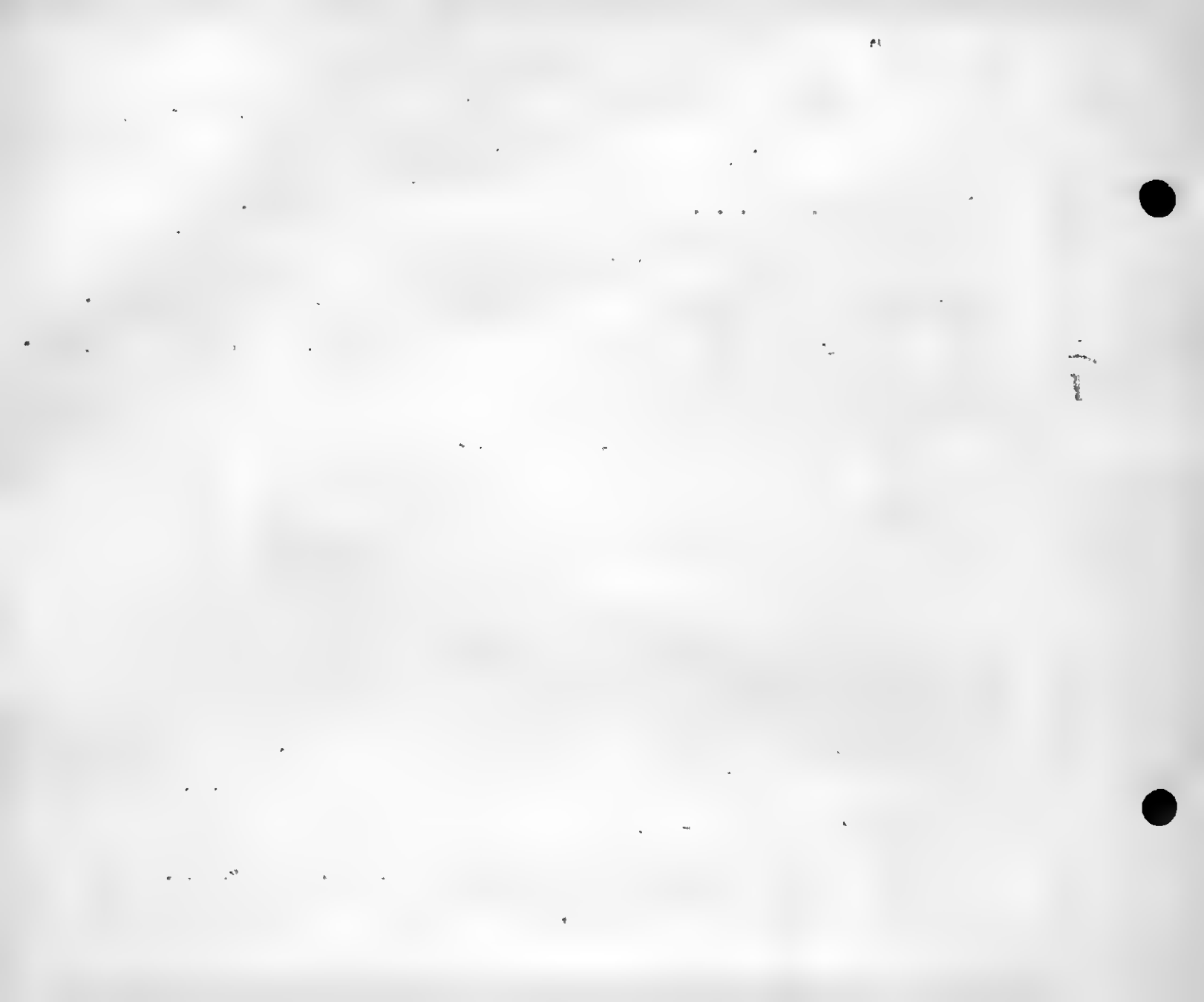




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23b Filed 12/3/68 12/3/68										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15616									
14070										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) First Middle Last <b>Racuel Eugenia Mabus</b>										2a. DATE OF DEATH Month Day Year <b>10 31 1968</b>										2b. HOUR <b>2:15 AM</b>									
3 SEX <b>Female</b>					4. RACE <b>White</b>					5. DATE OF BIRTH <b>10/29/68</b>					6. AGE (In years last birthday) YRS. MONTHS DAYS <b>2</b>					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>2</b>					IF UNDER 24 HRS. HOURS MIN <b>2</b>				
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Baltimore, Md.</b>														
10. CITY OR TOWN OF DEATH <b>Towson</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>					13c. CITY OR TOWN <b>Baltimore</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <b>3015 Putty Hill Ave.</b>									
14. FATHER'S NAME First Middle Last <b>Howard John Mabus</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Frances Jean Canavan</b>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> <b>772</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity &amp; Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>760:</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>While at work</b>					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED <b>While at work</b>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that I (this hospital) attended the deceased from <u>10/29/</u> , 19 <u>68</u> , to <u>10/31/</u> , 19 <u>68</u> , that I (we) last saw the deceased alive on <u>10/31/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Charles Feliciano M.D.</u>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Typed) <u>CHARLES A. FELICIANO, M.D.</u>										22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <u>11/19/68</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Maryland</u>					23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>														
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR <u>NOV 21 1968</u>					25b. REGISTRAR'S SIGNATURE <u>James L. Judge</u>														



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Robert Stewart MacEwan						Month Day Year October 22, 1968			M
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		June 30, 1906			62 YRS.		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Scotland		U.S.A.				Baltimore Md			
1d. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Ruxton			8415 Bellona La.			Manager Dept. Store			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	3d INSIDE CITY JIM TSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore		Ruxton			8415 Bellona La. Apt. 802	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John MacEwan			Jean Gray						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address Apt.				
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW II			058-09-6948		Mrs. Doris St. Jean MacEwan Ruxton Towers 802				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									Malignant glioma brain 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
1. -									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
8/68		Above			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5, 1959, to 10/22, 1968, that (I) (we) lost the deceased alive on 10/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED
Alan Bernstein									10/23/68
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		10/25/68		Baltimore National Cem.		Baltimore, Maryland			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson 1050 York Rd. 21204					DATE OCT 24 1968		J Charles Judge		



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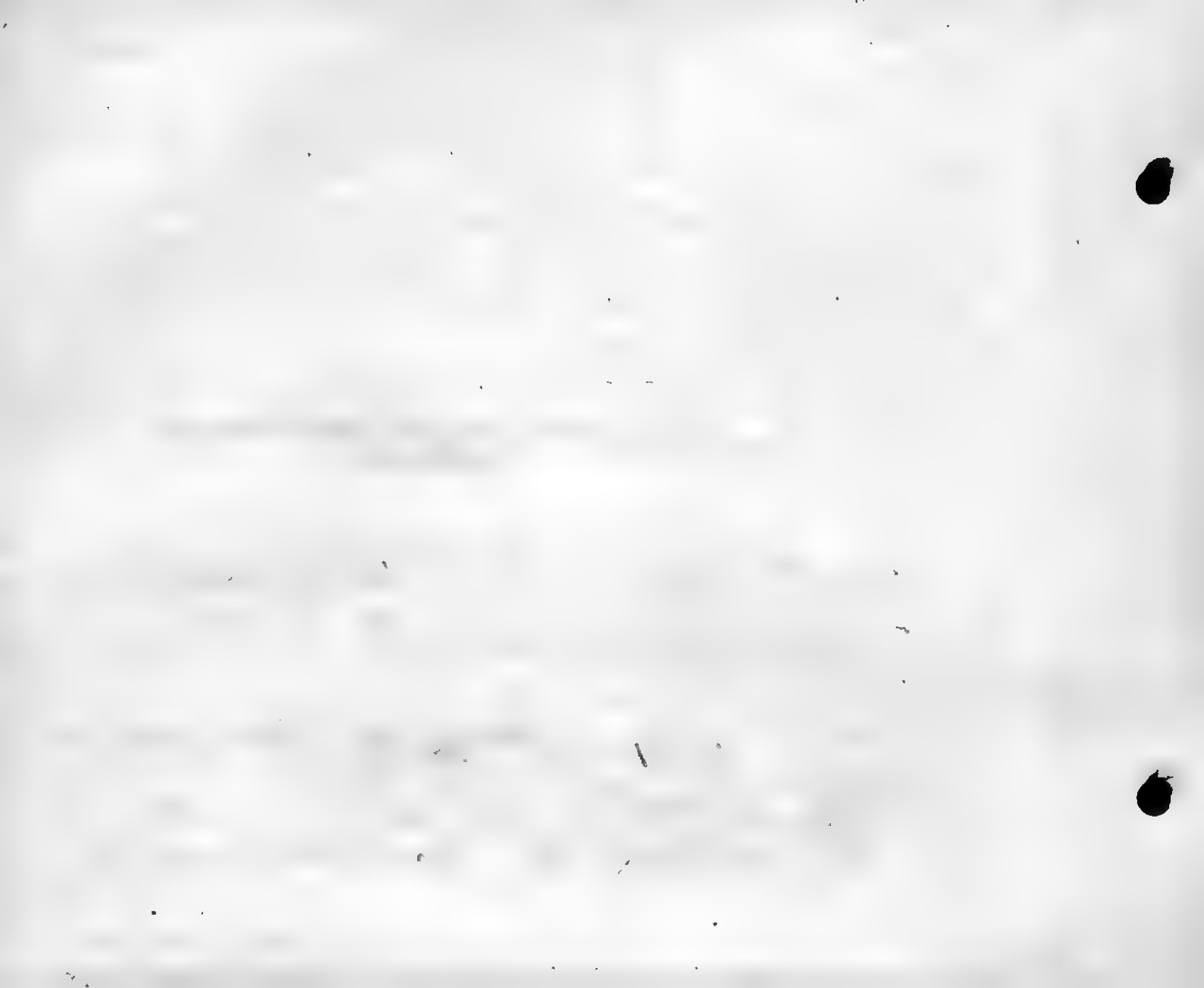
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
JULIUS			MACKS			OCTOBER 31 68			6:00 P.M.
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR	8 UNDER 24 HRS
MALE	WHITE		12-12-1896			71 YRS.		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
NEW YORK		U.S.A.				BALTIMORE Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
PIKESVILLE		MILFORD MANOR NURSING HOME			SALESMAN		REAL ESTATE		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE				2502 APACHE CIRCLE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
MAX JOSEPH MACKS			ROSE LEVINSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
YES W.W. I					NORTON MACKS-6100 PENHAURST ROAD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>									15 min
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Atherosclerosis (previous Coronaries)</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Arteriosclerotic Heart Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4 CVA - Old Left Hemiplegia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 1959, to 10/31, 1968, that (I) (we) last saw the deceased alive on 10/27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			George Sharfatz M.D. DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
								10-31-68	
22d. PHYSICIAN'S NAME (Type)			GEORGE SHARFATZ			22e. ADDRESS			
						6400 Park Heights Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		NOVEMBER 1968		HEBREW FRIENDSHIP		BALTIMORE		Md	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL. LEVINSON - BRASSIN			6010 REEBERS AVE			NOV 6 1968		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Joseph				Major	Oct. 2, 1968.				
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	White		Nov. 19, 1881.		86 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Hungary	USA				Baltimore Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Parkville		9637 Dixon Ave.		Retired-- Railroad Worker					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.		Baltimore				9637 Dixon Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Anthony Major			Rose ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		716-09-4358		Mrs. Rose Keane		(Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> +129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4331</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Recent Anorexia and Weakness (Not Ambulating)</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDER, YIELD <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1961</u> to <u>Oct 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Frank J. Ruck</u>		10/3/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
F.T. KASIK JR.		9005 HARBOR RD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/7/68.		Holy Cross Cemetery		Harrisburg, Pa.			
24. FUNERAL DIRECTOR ADDRESS				25a. OCT 4 1968		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Balto. Md. 21214									





## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First <b>James</b>	Middle <b>David</b>	Last <b>Manning</b>	2a. DATE OF DEATH Month <b>Oct.</b> Day <b>11</b> Year <b>1968</b>			2b. HOUR <b>12</b> MIN <b>12</b>		
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 31, 1924</b>		6. AGE (In years last birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Rosedale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8432 Coco Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Accountant</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rosedale</b>		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8432 Coco Road.</b>			
14. FATHER'S NAME First <b>James</b> Middle <b>Manning</b> Last <b>Lida</b>			15. MOTHER'S MAIDEN NAME First <b>Lida</b> Middle <b>Campbell</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes</b> <b>WW 2</b>			16b. SOCIAL SECURITY NO. <b>218-18-5715</b>		17. INFORMANT Address <b>Mrs. Barbara Manning 8432 Coco Road.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the intestines</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with Metastasis of the liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1539 Cachexia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Mid Sept, 1968</b> to <b>his death</b> (19 <b>1968</b> ), that (I) (we) last saw the deceased alive on <b>10/11</b> <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. John Geldrich MD</b>						DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/12/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>John Geldrich, M.D.</b>						22e. ADDRESS <b>8019 Philadelphia Road.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Ulrich Funeral Home 2112 Dundalk, Ave.</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14073

**CERTIFICATE OF DEATH**

14085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
RUTH				MULLIKEN	MARBURY	Month	Day	Year	2:10aM	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR		IF UNDER 24 HRS
Female		Caucasian		4/5/13		55 YRS.		MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Rye, N. Y.		U. S. A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson		Greater Balto. Med. Center		Housewife		Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Towson				622 Charles St. Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Harral			Mulliken			Patterson				
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
No			979-09-1640		Taylor M. Marbury		(Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma pancreas with widespread metastases</u>										
1579 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
157X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/28, 1968</u> , to <u>10/31, 1968</u> , that (I) (we) last saw the deceased alive on <u>10/31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		Charles C. Brown, M. D.				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED	
										October 31, 1968
22d. PHYSICIAN'S NAME (Type)		CHARLES C. BROWN, M.D.				22e. ADDRESS				
						Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Cremation		10/31/68		Greenmount		Baltimore			Md.	
24. FUNERAL DIRECTOR		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
						DATE NOV 4 1968		Charles Judge		

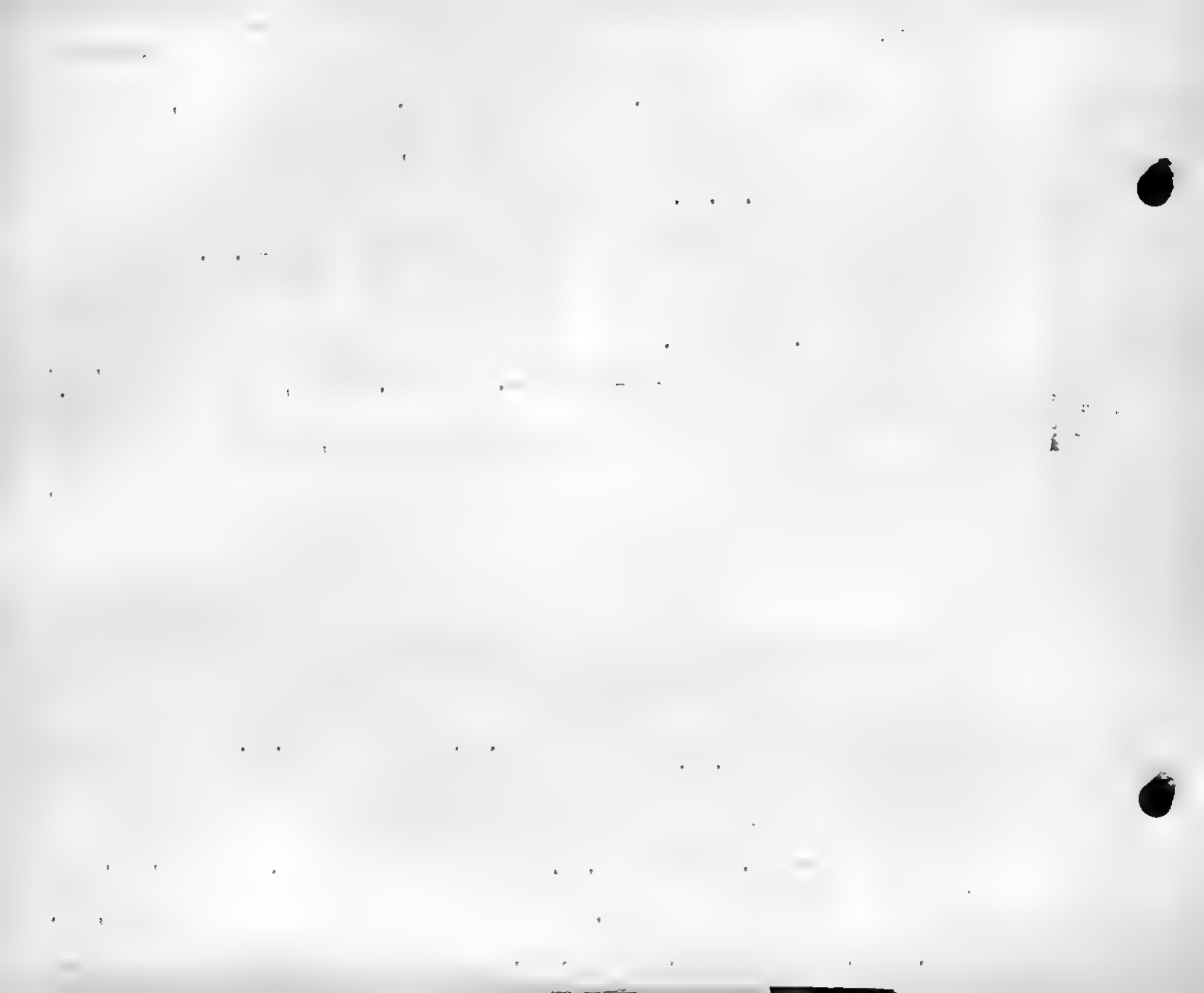


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit form. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR A 5-1-68  
304 REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14076		CERTIFICATE OF DEATH						14086			
1 DECEASED NAME (Type or print) <b>Ralph</b>			First <b>J.</b>		Middle <b>Martin Jr.</b>		Last		2a. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1968</b>	2b. HOUR M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>April 16, 1919</b>			6 AGE (in years last birthday) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 MRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10 CITY OR TOWN OF DEATH <b>Dundalk</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8124 Longpoint Road</b>			12a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Truck Driver-W. D. Cowan</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8124 Longpoint Road</b>			
14. FATHER'S NAME First <b>Ralph J.</b> Middle <b>Martin Sr.</b> Last			5 MOTHER'S MAIDEN NAME First <b>Mary Helen</b> Middle <b>Keihley</b> Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, state war or dates of service) <b>WWII</b>					
16b. SOCIAL SECURITY NO <b>217-09-0677</b>			17 INFORMANT (Wife) <b>Mrs. Sheila P. Martin, 8124 Longpoint Rd.</b>			Address <b>Dundalk, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>metastatic adenocarcinoma, pancreas</b>										<b>10 mos</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>diabetes mellitus</b>										<b>6 mos.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
157x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>11.17.56</b> , 19 <b>56</b> , to <b>9.25.68</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>9.25.68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Eugene F. Nevy M.D.</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/2/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Eugene F. Nevy</b>		M. D.		22e. ADDRESS <b>7001 Morningson Rd. Dundalk, Md. 21222</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 5 Film 405 10-7-68											
14077 CERTIFICATE OF DEATH 14087											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
CORRA			MATHANEY			10 10 68			10A M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		White		11-28-1885		83 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			CHESAPEAKE MANOR			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Balto.		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1200 Providence Rd.		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
George W Leonard			Mollie ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address						
No					Edgar H Mathaney 1324 Roxboro Rd. 21237						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> <u>1100V</u> DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis (b) DUE TO, OR AS A CONSEQUENCE OF Degenerative joint disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1968</u> , to <u>Oct 9, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Oct 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jamshed Hamer MD</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>JAMSHED HAMER MD</u>						22e. ADDRESS <u>Towson 9, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		10/14/68		Garden of Faith Cem		Baltimore				Md.	
24 FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lassahn Funeral Home 7401 Belair Rd. 21236						DATE <u>OCT 14 1968</u>		<u>J. J. Judge</u>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14078

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14088

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Marie, Middle M., Last Mattison		2a. DATE OF DEATH Month OCT, Day 19, Year 1968		2b. HOUR 11:55 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/14/98	
7a. BIRTHPLACE (State or foreign country) Balto.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County General		9. COUNTY OF DEATH Baltimore Md	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
14. FATHER'S NAME First John Middle Helmsker Last		15. MOTHER'S MAIDEN NAME First Louisa Middle Botenborg Last		13c. CITY OR TOWN Balto. 7	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 219-18-8475		17. INFORMANT Address 7514 Windsor Mill Rd. Mrs Dorothy L. Zimmerman	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intractable Left Ventricular Failure					
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarctions x 2					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Atherosclerotic Cardiovascular Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 20, 1968, to Oct 5, 1968, that (I) (we) saw the deceased alive on Oct 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gregorio Marfoni				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Gregorio Marfoni				22e. ADDRESS Balto Co. General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt Olive Cemetery	
24. FUNERAL DIRECTOR Loring Byers		ADDRESS 8728 Liberty Road.		23d. LOCATION (City or Town) (County) (State) Randallstown, Md.	
25a. RECD BY REGISTRAR DATE OCT 8 1968				25b. REGISTRAR'S SIGNATURE Charles Judge	



14079

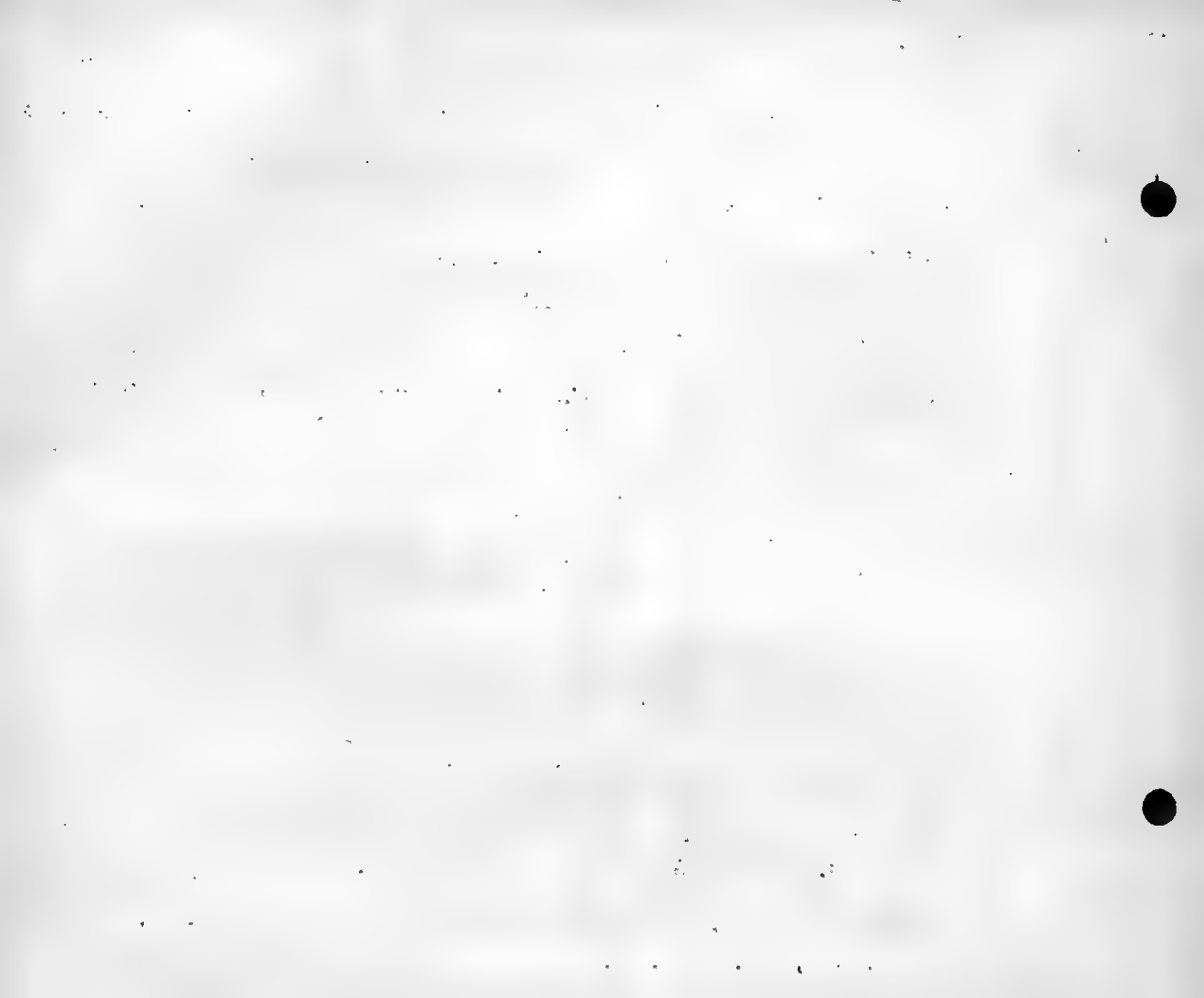
14089

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>CHARLES P. McGEENEY</b>			2a. DATE OF DEATH Month <b>10</b> - Day <b>14</b> - Year <b>68</b>			2b. HOUR <b>6:30 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>4-8-86</b>		6. AGE (In years last birthday) <b>82</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>STELLA Marie Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Policeman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>4614 Northwood Drive</b>		14. FATHER'S NAME First <b>OWEN J.</b> Middle <b>McGEENEY</b> Last <b>McGEENEY</b>		15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>YATES</b> Last <b>YATES</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>216-01-1275</b>		17. INFORMANT <b>Mr. Owen R.E. McGeeney,</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1201 DIABETES MELLITUS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-7</b> , 19 <b>68</b> , to <b>10-14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. David Nagel</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-14-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>J. David Nagel</b>				22e. ADDRESS <b>812 Mocking Bird Lane Baltimore 21204</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/17/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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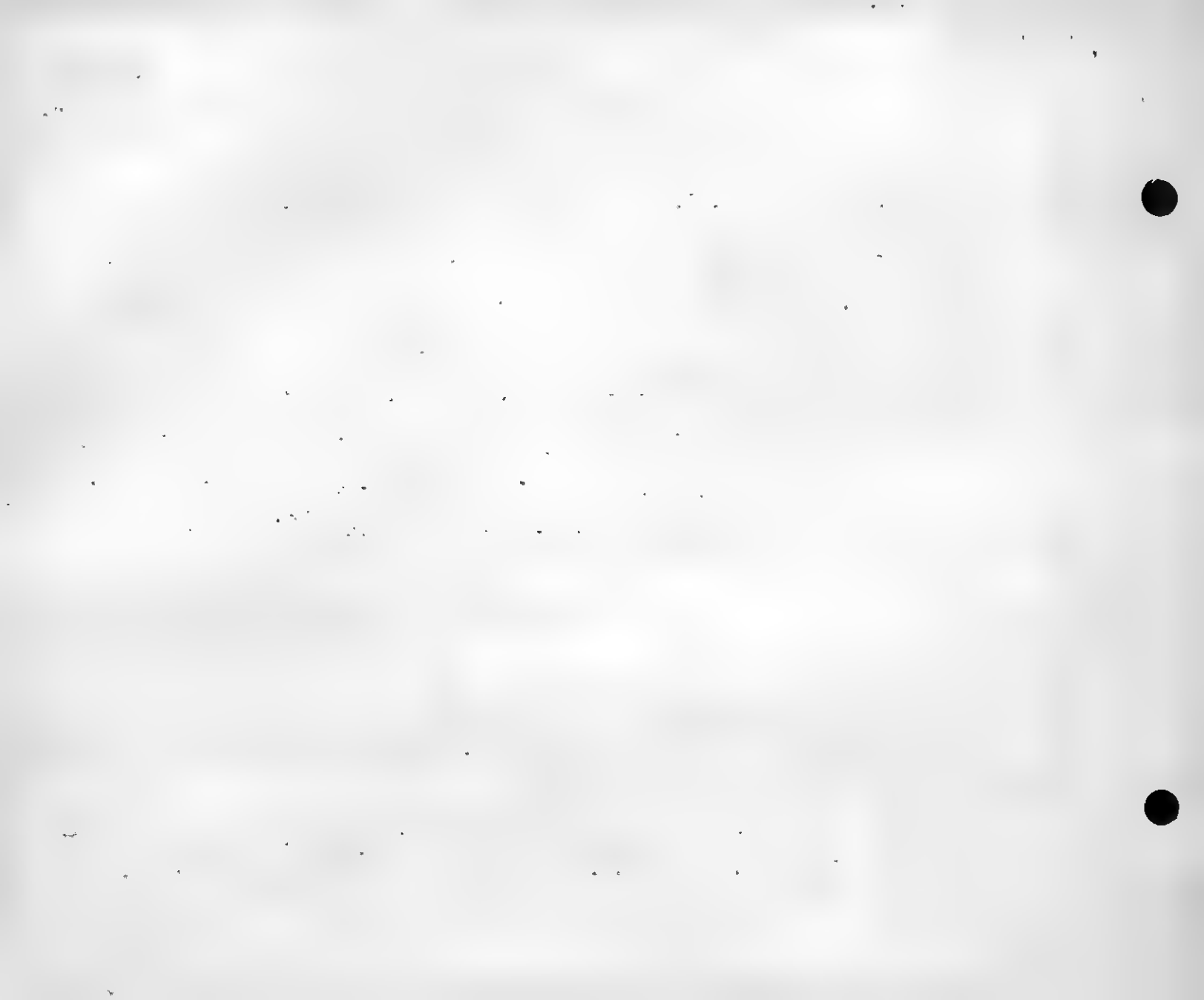
1 14080

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 23 & 24 taken from burial permit 118662 kk

# CERTIFICATE OF DEATH

14090

1 DECEASED-NAME (Type or print) First Middle Last Carl William McLain			2a. DATE OF DEATH Month Day Year October 5, 1968			2b. HOUR 3:00 p. M.					
3 SEX male		4 RACE white		5. DATE OF BIRTH May 25, 1901		6. AGE (in years lost birthday) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) maintenance man			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY —		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4719 Eastern Avenue		
14. FATHER'S NAME First Middle Last John			15. MOTHER'S MAIDEN NAME First Middle Last Joda Louis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 213-01-4130		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - Or pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Pulmonary Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>and chronic Bronchitis.</i> Conditions, if any, which gave rise to immediate cause (a), showing the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Oct. 13, 1961, to Oct. 5, 1968, that (X) (we) last saw the deceased alive on Oct. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Rafael H. Marin</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/14/68			
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.						22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL			23b. DATE 11/1/68		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR ADDRESS Newell Funeral Home. Pikesville, Md.						25a. REC'D BY REGISTRAR DATE OCT 16 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

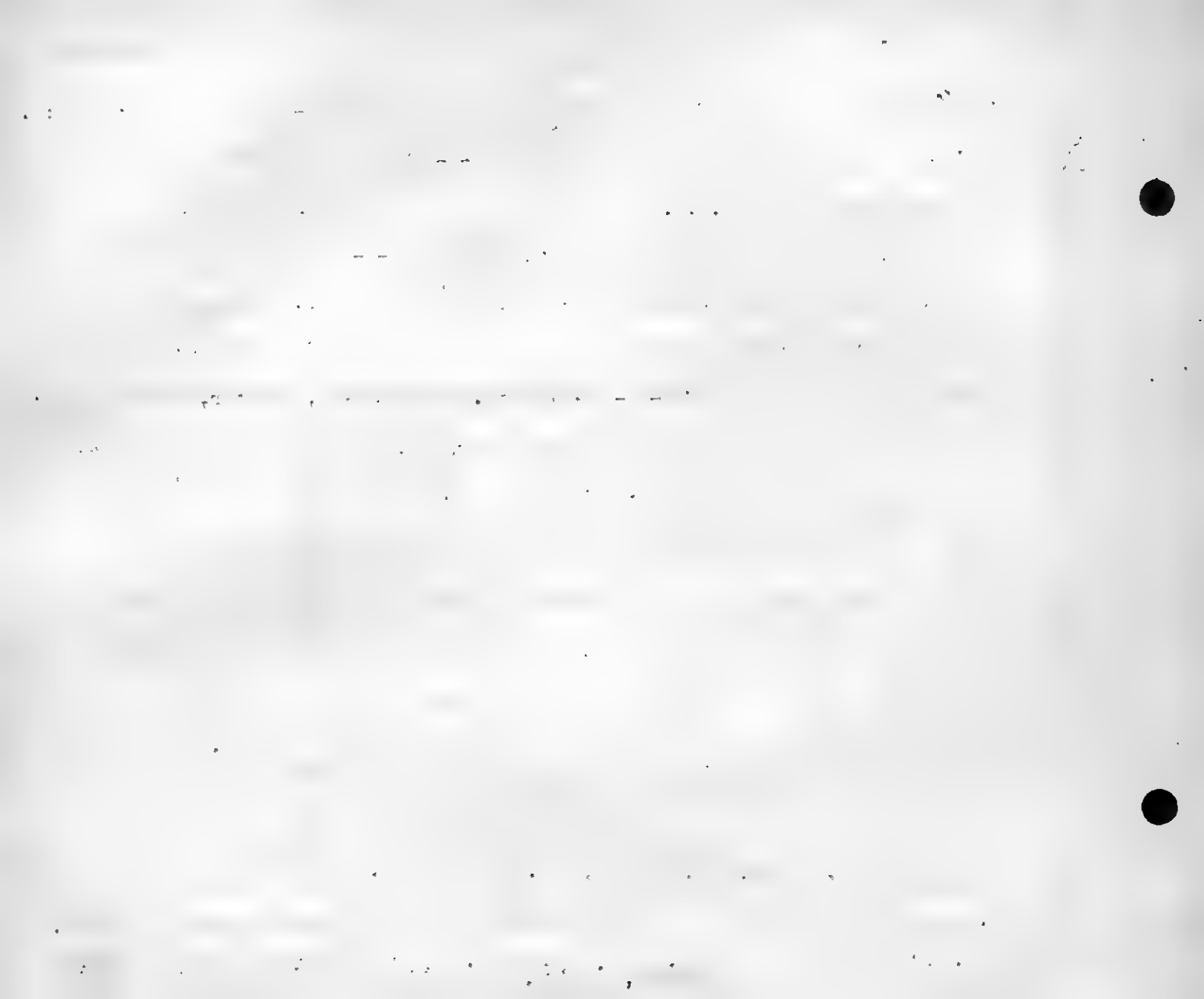


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VR 15-64  
30M REV 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14081		CERTIFICATE OF DEATH						14091	
1 DECEASED-NAME (Type or print) ALICE THROCKMORTON McLEAN			First Middle Last			2a DATE OF DEATH 10-25-1968		2b. HOUR 9:A. M.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 3-8-1886		6 AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) NEW YORK CITY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE, COUNTY Md			
10 CITY OR TOWN OF DEATH LUTHERVILLE, MD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) COLLEGE MANOR NURSING HOME		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) -		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY HARFORD		13c CITY OR TOWN Bel Air		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 80 BROADWAY	
14 FATHER'S NAME JAMES McLEAN			First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last SARA THROCKMORTON			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO 219-56-5506		17 INFORMANT Address Mrs. James McLean, Bel Air, Maryland 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Degenerative &amp; cerebral arterio-sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>64</u> , to <u>present</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>two weeks ago</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE <u>Ernest C. Brown Jr. M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/25/68			
22d PHYSICIAN'S NAME (Type) Dr. Ernest C. Brown, Jr.		22e ADDRESS 550 N. Broadway							
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 10/25/68		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Baltimore 12, Md.		25a REC'D BY REGISTRAR OCT 25 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~executed~~ within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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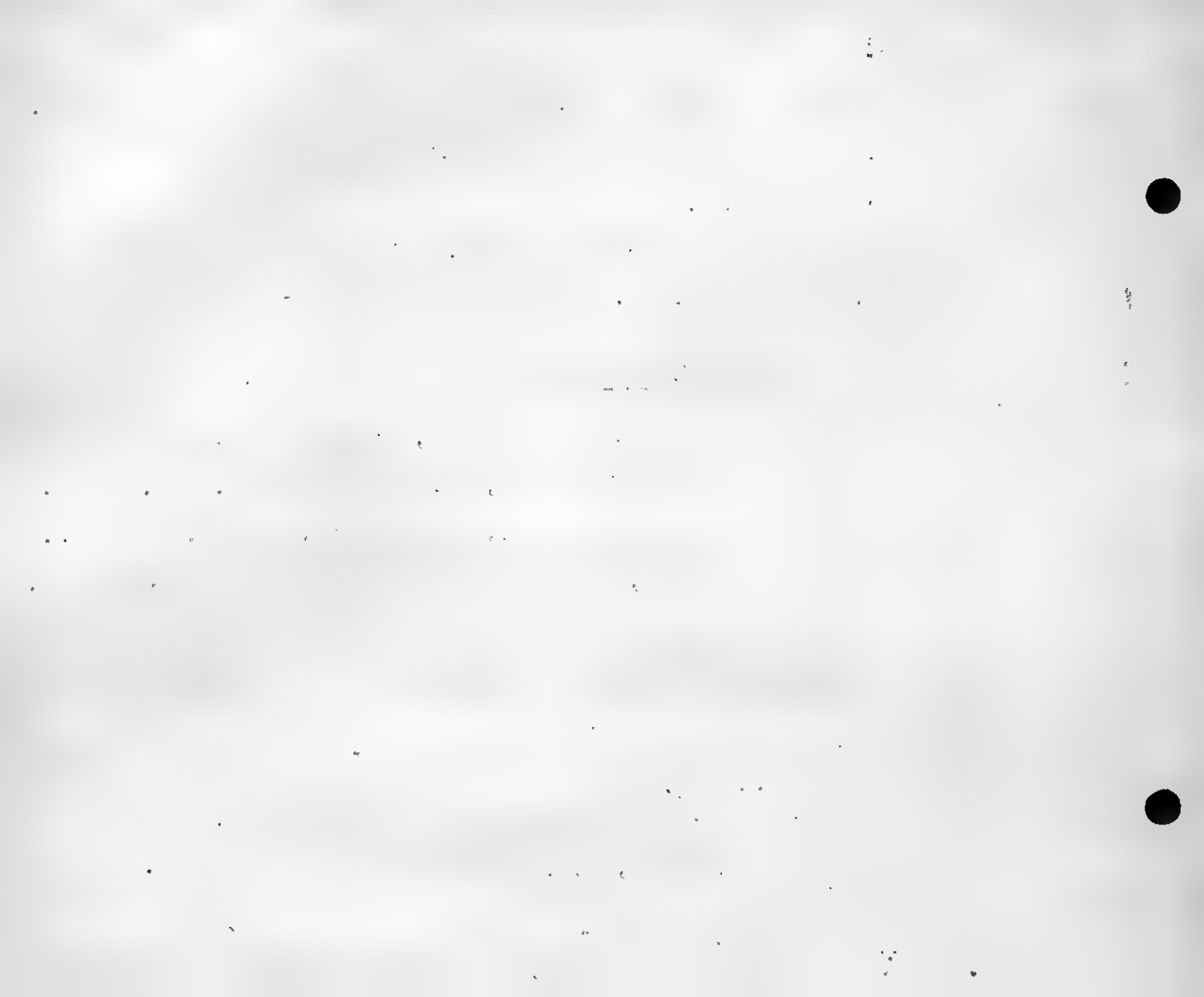
14082

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14092

1. DECEASED NAME (Type or print) First Middle Last Hiram Thomas Meredith			2a. DATE OF DEATH Month Day Year October 15, 1968			2b. HOUR 10:45 a. M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH May 15, 1903		6. AGE (in years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) tile layer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 432 Maury Lane		14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-01-3702		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic, cardiovascular ht. dis. 2 yrs. (b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis, Generalized, senile. 2 yrs. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Calcification of iliac, femoral, and popliteal arteries by x-ray.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from Jan. 13, 1966, to Oct. 15, 1968, that (X) (we) last saw the deceased alive on Oct. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Anthony J. Young, M.D.				22c. DATE SIGNED 3:00PM 15 Oct 68		22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
23a. BURIAL CREMATION REMOVA (Specify)		23b. DATE 10/19-1967		23c. NAME OF CEMETERY OR CREMATORY Washington Hall		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co. Md.	
24. FUNERAL DIRECTOR 131-11th St. S.E.				25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14083

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14093

1 DECEASED NAME (Type or print) <i>Esther Miller</i>			2a. DATE OF DEATH Month <i>October</i> Day <i>15</i> Year <i>1968</i>			2b. HOUR <i>12 noon</i>								
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 24, 1878</i>		6. AGE (In years last birthday) <i>70</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>				
7a BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.								
10. CITY OR TOWN OF DEATH <i>Pikesville</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Professional House</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>Emerson Ave</i>		
14. FATHER'S NAME First <i>Louis</i> Middle <i>Lesser</i> Last <i>Rosalia</i>			15 MOTHER'S MAIDEN NAME First <i>Rosalia</i> Middle <i>Road</i> Last <i>Round Harbor</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>428X</i>			17 INFORMANT <i>Mrs Hilda Abramson</i> Address <i>3507 Round Harbor Road</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Insufficiency</i> <i>428X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>old age</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION <i>1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>10</i> Day <i>15</i> Year <i>1968</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No <i>1915</i> City or Town <i>Catonsville</i> County <i>Baltimore</i> State <i>Md</i>										
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 13, 1968</i> , to <i>Oct 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 13, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Samuel Legum</i>						DEGREE <i>MD</i> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>October 16/68</i>						
22d. PHYSICIAN'S NAME (Type) <i>SAMUEL LEGUM</i>						22e. ADDRESS <i>MEDICAL ARTS BLDG.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Oct 16/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chapel Amuro</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>								
24. FUNERAL DIRECTOR <i>Sal Leunson</i>						ADDRESS <i>2121 - 6010 Rest. Rd.</i>		25a. REC'D BY REG. STRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



## CERTIFICATE OF DEATH

14084

14094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
IRVIN			LEVI	MILLER	OCTOBER 12, 1968			2:17p.M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE		WHITE		SEPTEMBER 9, 1905		63 YRS		MONTHS DAYS		HOURS M.N
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				BALTIMORE 4 Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON			ST. JOSEPH HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Baltimore		Overlea				6 West Elm Avenue 6	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Brant A. Miller			unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			217-03-4650		Mrs Martha R. Miller 6 West Elm Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u>										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u>Coronary Thrombosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>Sept. 21, 1968</u> , to <u>Oct. 12, 1968</u> , that <del>he</del> (we) last saw the deceased alive on <u>Oct. 12, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>(did not)</del> view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
<u>I Cilliani</u>			Oct. 12, 1968							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Ines Cilliani MD			7620 York Road, Towson 4, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10-16-1968		Gardens of Faith Cemetery		Baltimore Co. Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Lassahn Funeral Home 7401 Belair Road 21236				OCT 16 1968		<u>J. Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14085

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14085

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>John K. Miller</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>15</b> Year <b>1968</b>		2b. HOUR <b>11</b> AM
3. SEX <b>M</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>May 1, 1900</b>		6. AGE (In years lost birthday) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cockeysville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>10303 Greenside Dr.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. CITY <b>Baltimore</b>	13c. CITY OR TOWN <b>Cockeysville</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <b>10303 Greenside Dr.</b>
14. FATHER'S NAME First <b>W. Booth</b> Middle <b>Miller</b>			15. MOTHER'S MAIDEN NAME First <b>Emma B.</b> Middle <b>Frederick</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>056 05 0870</b>	17. INFORMANT Address <b>Nancy Lou Nickles, Cockeysville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CEREBRO-VASCULAR DISEASE</b> <b>4077</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/22, 1968</b> , to <b>10/15, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/11, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William A. Polesbury M.D.</b>		22c. DATE SIGNED <b>10-14-68</b>		22d. PHYSICIAN'S NAME (Type) <b>William A. Polesbury</b>	
22e. ADDRESS <b>Towson, Md.</b>		22f. ADDRESS <b>Towson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 16, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
23d. LOCATION (City or Town) <b>Baltimore,</b>		(County) <b>Baltimore,</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>		25a. REC'D BY REGISTRAR <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

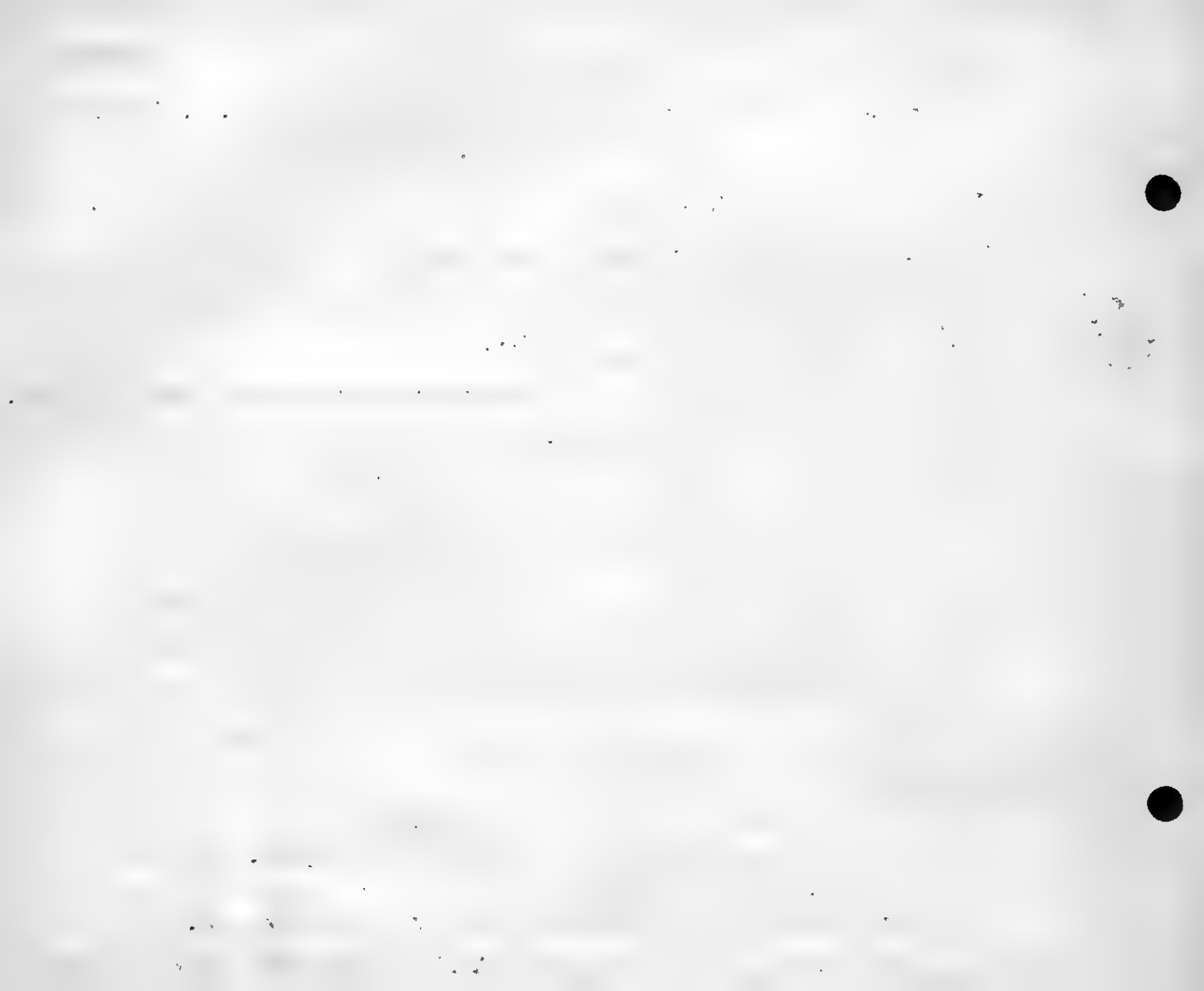
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14086

CERTIFICATE OF DEATH

14096

1. DECEASED NAME (Type or print) <b>TERESA MILLER</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>3</b> Year <b>1968</b>		2b. HOUR <b>10:30 P M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Nov. 24, 1885</b>		6. AGE (In years last birthday) <b>82</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore Co., Md</b>		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Ridgeway Manor Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Baltimore City</b>	13b. CITY OR TOWN <b>Baltimore City</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>2626 Maempel Lane 21223</b>		
14. FATHER'S NAME <b>Unk.</b>	15. MOTHER'S MAIDEN NAME <b>Unk.</b>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. ?		17. INFORMANT <b>Ridgeway Manor Nursing Home, Catonsville, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>431.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> to <b>3 Oct 1968</b> ; that (I) (we) last saw the deceased alive on <b>3 Oct 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William Goodman</b>	DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>7 Oct 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM GOODMAN MD</b>	22e. ADDRESS <b>1831 Suburban Rd</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/9/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>OCT 10 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

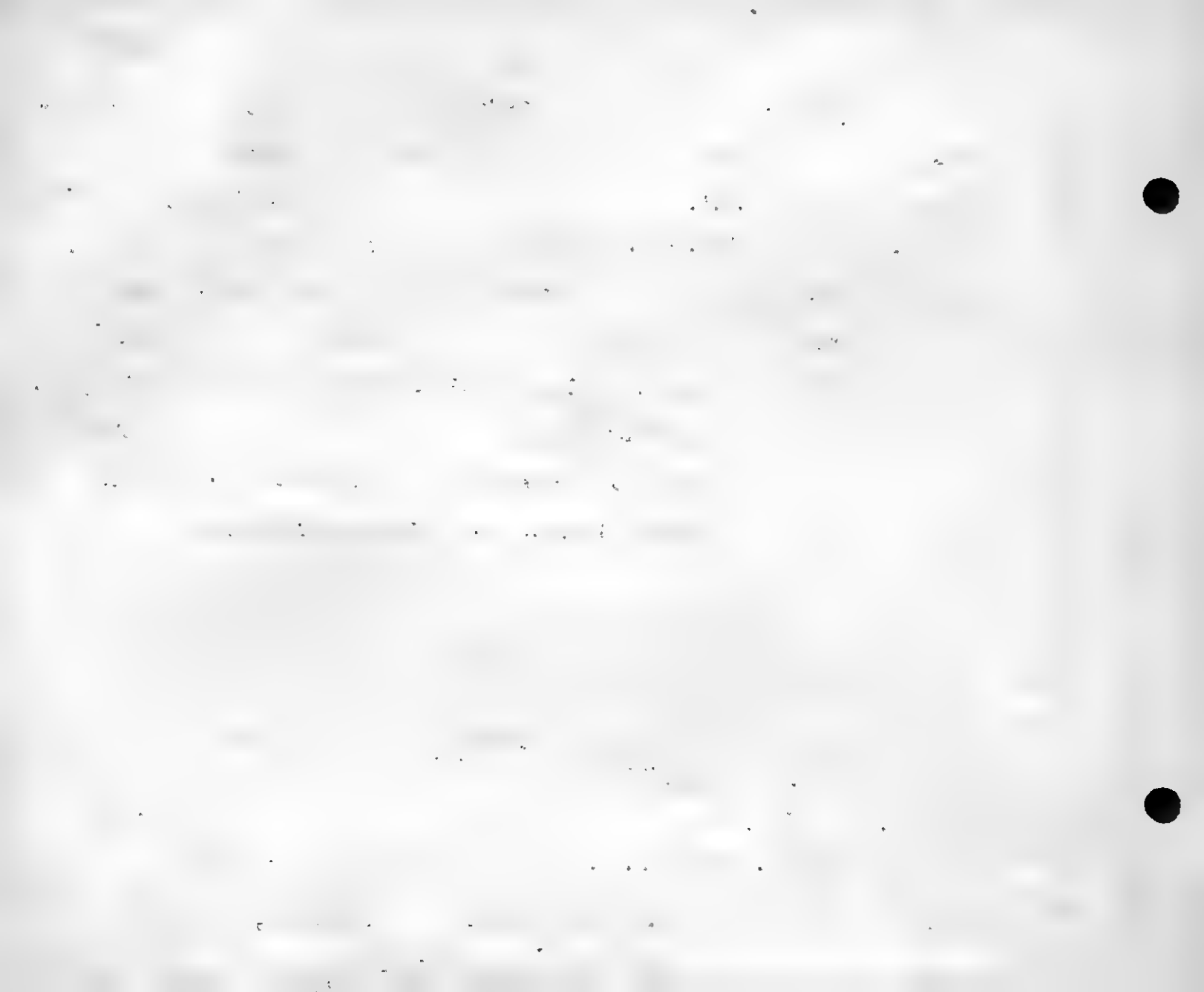
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

MIDDLE										LAST										2a. DATE OF DEATH										2b. HOUR																													
1 DECEASED-NAME (Type or print)										HERBERT										MILLS										Month 10 Day 15 Year 68										6:05 A M																			
3. SEX										4 RACE										5. DATE OF BIRTH										6 AGE (in years birth day)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN.									
MALE										NEGRO										12/19/15										52 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH																													
MARYLAND										U.S.A.																				BALTIMORE COUNTY, MARYLAND																													
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																													
FORT HOWARD										VET. ADM. HOSPITAL										CRANE OPERATOR										METAL CO.																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIMITS?										13e STREET AND NUMBER																			
MARYLAND																				BALTIMORE										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										3100 Windsor Avenue																			
14 FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
HERBERT										MILLS										SADIE										CHASE																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b SOCIAL SECURITY NO.										17. INFORMANT										Address																													
YES										WW II										216 09 92 23										CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY.										BRONCHOPNEUMONIA										RECENT																																							
IMMEDIATE CAUSE (a)																																																											
DUE TO, OR AS A CONSEQUENCE OF										METASTATIC ADENOCARCINOMA, RIGHT LUNG AND PLEURA										OLD																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)																																																	
DUE TO, OR AS A CONSEQUENCE OF										(c) SURGICAL ABSENCE, LEFT KIDNEY (HYPERNEPHROMA)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY?										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										YES																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 10/4/68, 19, to 10/15/68, 19, that (I) (we) last saw the deceased alive on 10/15/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b SIGNATURE										ERHARD J. BUNYOR										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 10/15/68																													
22d. PHYSICIAN'S NAME (Type)										ERHARD J. BUNYOR, M. D.										22e ADDRESS										VAN FORT HOWARD, MARYLAND																													
23a. BURIAL, CREMATION, REINBURSEMENT (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)																													
BURIAL										10-18-68										BALTIMORE NATIONAL										BALTIMORE, MARYLAND																													
24 FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REG. STRAR										25b. REGISTRAR'S SIGNATURE																													
										MORTON & DYETTE FUNERAL HOME										25a. REC'D BY REG. STRAR										25b. REGISTRAR'S SIGNATURE																													
										1701 E. LAURENS ST. BALTIMORE, MD.										25a. REC'D BY REG. STRAR										25b. REGISTRAR'S SIGNATURE																													

MORTON & DYETTE FUNERAL HOME  
1701 E. LAURENS ST. BALTIMORE, MD.

25a. REC'D BY REG. STRAR  
25b. REGISTRAR'S SIGNATURE  
1968 Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14088		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14098		
CERTIFICATE OF DEATH								
1 DECEASED-NAME (Type or print) First Middle Last VIOLA MILLS			2a DATE OF DEATH Month Day Year October 15 1968			2b HOUR 1P. M.		
3. SEX Female		4 RACE White		5 DATE OF BIRTH Nov. 14, 1884.		6. AGE (In years last birthday) 83 YRS		
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1702 Goodview Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTRY Balto		13c CITY OR TOWN Parkville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER 1702 Goodview Rd.								
14. FATHER'S NAME First Middle Last John Goldwine			15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Sakaites					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b SOCIAL SECURITY NO (If yes give year or dates of service) 214-18-6994		17 INFORMANT Mrs. Margaret L. Shanahan, 1702 Goodview Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease 26 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Just prior to		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from _____, 1958, to Oct. 10, 1968, that (I) (we) last saw the deceased alive on 10/15/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE Dr. S. Elliott Harris				22c DATE SIGNED 10/15/68				
22d. PHYSICIAN'S NAME (Type) Dr. S. Elliott Harris				22e. ADDRESS 8100 Harford Rd., Balto. 34, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/18/68.		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.				25a. REC'D BY REGISTRAR DATE OCT 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 10 Film 4106  
10/30/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
14099  
14083  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Anna</b>		First <b>Anna</b>		Middle		Last <b>Mitchell</b>		2a. DATE OF DEATH <b>Oct</b> Month <b>12th</b> 19 <b>68</b>				2b. HOUR M	
3. SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>7-13-1887</b>				6 AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>							
10 CITY OR TOWN OF DEATH <b>Baltimore Co.</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address) <b>6821 Alter St.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Balt.</b>		13c. CITY OR TOWN —		13d. INSIDE CITY, MD? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>6821 Alter St.</b>			
14 FATHER'S NAME First <b>Melchor</b>				Middle		Last		15 MOTHER'S MAIDEN NAME First <b>Elizabeth</b>				Middle <b>Kubns</b> Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO		17 INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arterio-sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>450c</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Nathan B. Herman, M.D.</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10/12/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>Nathan B. Herman</b>		22e. ADDRESS <b>5510 Ireland Ave.</b>											
23a. BURIAL, CREMATION, OR MOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rummel/Luth Cem.</b>		23d. LOCATION (City or Town) <b>Paint Township, Pa.</b>		(County)		(State)			
24 FUNERAL DIRECTOR <b>Wm. J. Tichner &amp; Son, Balt., Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

16090

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14100

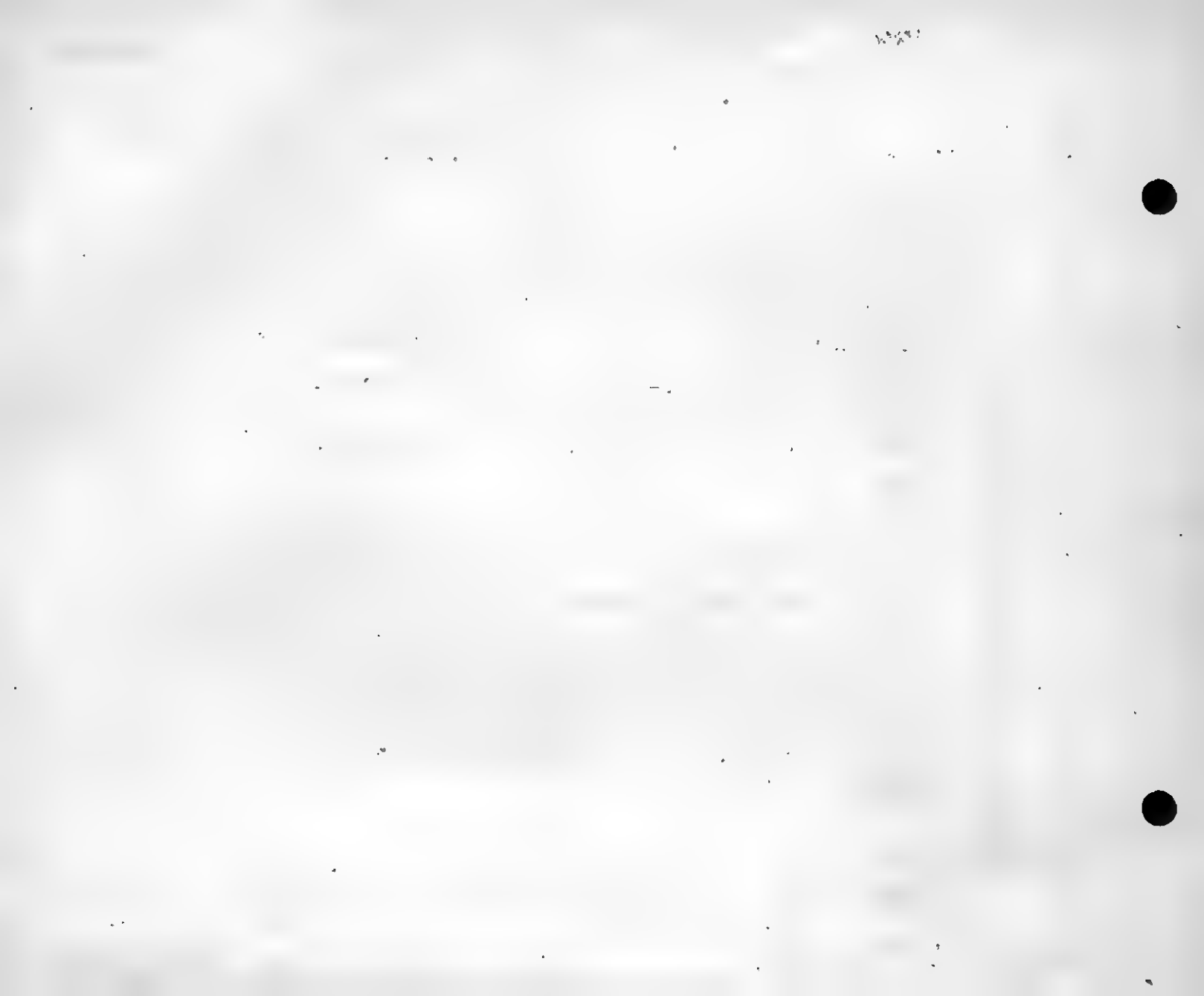
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year 19			2b HOUR 9a M				
3 SEX male		4 RACE white		5 DATE OF BIRTH July 4 1895		6 AGE (In years last birthday) 73 YRS		7 MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD 10-5-68 Day Year 19		2d HOUR 9a M	
7a BIRTHPLACE (State or foreign country) Lithuania			7b. CITIZEN OF WHAT COUNTRY? U. S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Balto.			Md	
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Spring Grove State Hosp			12a USUAL OCCUPATION (Kind of work done during working life, even if retired) tailor			12b KIND OF BUSINESS OR INDUSTRY				
3a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Md.			13b COUNTY			13c CITY OR TOWN Balto.			13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 34 S. Carey St.	
14 FATHER'S NAME John Mikalanakas			First Middle Last			15 MOTHER'S MAIDEN NAME Ona Chiancus			First Middle Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO 215-16-9053A			17 INFORMANT Records; Spring Grove osp.			ADDRESS				
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia											3 weeks		
2509 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost													
(b) Nephrosclerosis													
(c) Diabetes Mellitus											25 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
260x Fracture hip													
19a. DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 9-25-68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) fall							
21d INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHERE <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) Spring Grove Hosp			21f LOCATION Street or R.F.D. No City or Town County State			Catonsville Md. Balto. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE J. Nelson McKay			EXAMINER'S NAME (Type) J. Nelson McKay			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 10-5-68				
23a BURIAL CREMATION REMOVAL (Specify) Burial			23b DATE Oct 10 1968			23c NAME OF CEMETERY OR CREMATORY new cathedral			23d LOCATION City or Town County State Old French Road Balto Md				
24 FUNERAL DIRECTOR Krause Funeral Home			ADDRESS 1216 S Charles St			25a REC'D BY REGISTRAR DATE OCT 14 1968			25b REGISTRAR'S SIGNATURE [Signature]				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPT. OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14091					14101				
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
First Middle Last Mable M Mitter					Month Day Year October 10 1968		6 00 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. COUNTY OF DEATH	
female		white		Feb. 5, 1896		62 YRS.		Baltimore Md.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
West Virginia		U S A							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Reisterstown		Cent Nursing Home		housewife		at home			
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Linthicum		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		None			
14. FATHER'S NAME First Middle Last			15. MOTHER'S M A D E N NAME First Middle Last						
Ellis Menear			<del>XXXXXXXXXX</del> Sarah Poe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No		236-32-6823		Mildred Mitter, Linthicum, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lymphoma, lymphoblastic</u>								7 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) _____ DUE TO, OR AS A CONSEQUENCE OF									
(c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Aug 7, 1968, to Oct 10, 1968, that (I) (we) last saw the deceased alive on Oct 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C E McWilliams MD				22c. DATE SIGNED 10-10-68					
22d. PHYSICIAN'S NAME (Type) 11904 Reisterstown Rd Reisterstown Md				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		10/13/68		Framsville		Newburg W. Va			
24. FUNERAL DIRECTOR John R. Slack				24b. CITY		24c. REGISTRAR'S SIGNATURE			
Ellicott City Md.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				OCT 15 1968		Charles Judge			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14092

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14102

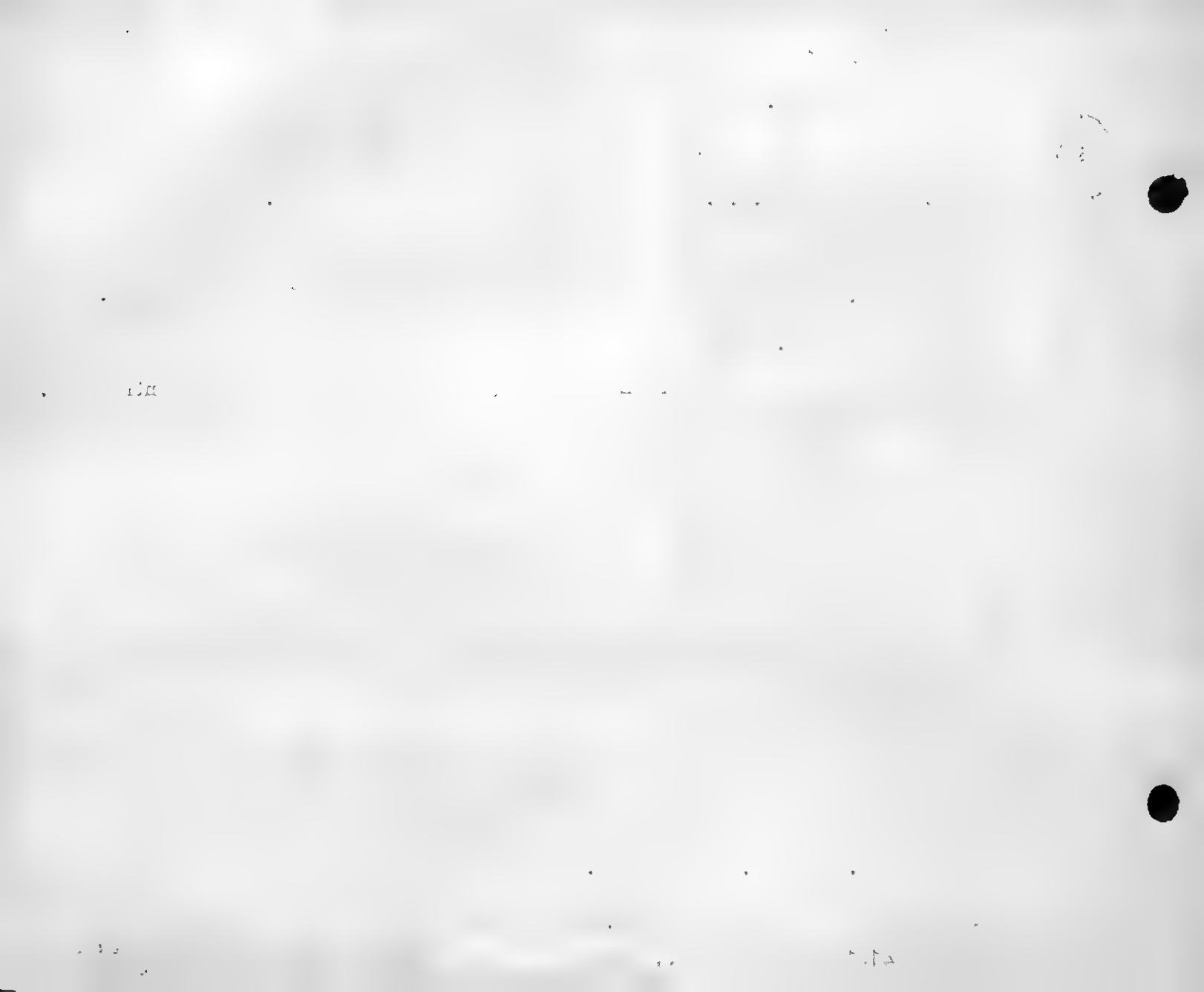
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <input type="checkbox"/> 19			2b. HOUR M
MILDRED			REGINA			MOHR			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PROMOUNCED DEAD Month Day Year	2d. HOUR P. M
Female	White	2-28-1917	51 YRS					October 16, 1968	8:15 P. M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.A.				BALTIMORE Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Fullerton (Rural)			4244 Thorncliff			Clerk			A. & P. Stores
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Baltimore		Fullerton			4244 Thorncliff Rd 21236	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John Thomas			Kearney			Catherine A.			Shelly
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS
No			213-03-6315			Mr. Edward F. Greives Rt#2 Finksburg, Md			21048
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Overdose of barbiturate</u>									
7500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) _____ DUE TO, OR AS A CONSEQUENCE OF									
(c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
					Took overdose of barbiturates				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
		Home		4244 Thorncliff		Baltimore		Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Charles S. Springate M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 17, 1968	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		10-19-1968		Parkwood Cemetery		Parkville		Balto. Co	Md.
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home 7401				Belair Road 21236		DATE OCT 22 1968		j Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14098										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14103				
1 DECEASED-NAME (Type or print)										2a DATE OF DEATH										2b HOUR				
Clyde R. Morrow										10 Month 22 Day 68 Year										10 M				
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)			7 UNDER 1 YEAR			8 UNDER 24 HRS									
Male			White			May 24, 1885			83 YRS			MONTHS			DAYS									
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 COUNTY OF DEATH															
New York			U.S.A.			WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Balto.															
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY															
Catonsville			House of the Pines			Retired																		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER												
Md.			Balto			Balto			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5514 Gwynn Oak Ave., 21215												
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME																			
George E. Morrow					Ida																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No					220-05-1595A					Mr. Miles Morrow, 670 Cross Country Blvd.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										3 d														
DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) <u>Chronic Atherosclerotic Cardiovascular Disease</u>														
										15 yr														
DUE TO, OR AS A CONSEQUENCE OF										(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
4221 Acute Bronchitis																								
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING					21b TIME OF INJURY					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					HOUR A.M. Month Day Year																			
					P.M. 19																			
21d INJURY OCCURRED					21e PLACE OF INJURY (AT HOME FARM, STREET FACTORY OFFICE BUILDING, ETC.)					21f LOCATION					Street or R.F.D. No. City or Town County State									
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																								
22a. I certify that (I) (this hospital) attended the deceased from <u>10-18</u> , 19 <u>68</u> , to <u>10-22</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>10-22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										22c. DATE SIGNED														
<u>Dr. Wilmer K. Gallagher, Sr.</u>										10-24-68														
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS														
Dr. Wilmer K. Gallagher, Sr.										6209 Frederick Road														
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					23d LOCATION (City or Town) (County) (State)									
Burial					10/24/68					Lounston Park Cemetery					Baltimore, Maryland									
24 FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. DECEASED'S NAT'L				
Witzke, 4101 Edmondson Ave., 21229										OCT 25 1968										Judge				





## CERTIFICATE OF DEATH

14096

14104

1. DECEASED NAME (Type or print) <i>Mary</i>			First <i>E.</i> Middle <i>Mosner</i> Last		2a. DATE OF DEATH <i>Oct.</i> Month <i>18</i> , Day <i>1968</i> Year			2b. HOUR M	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>October 29, 1884</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>		Md	
10. CITY OR TOWN OF DEATH <i>Reisterstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>109 Glyndon Drive</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>109 Glyndon Drive</i>	
14. FATHER'S NAME <i>Randolph</i>			First <i>Slade</i> Middle Last		15. MOTHER'S MAIDEN NAME <i>Alverta</i>			First <i>Morrison</i> Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i> (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <i>213-07-1982</i>		17. INFORMANT <i>Mrs. J. Edward Hewes</i>		Address <i>Reisterstown, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio-vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) <input checked="" type="checkbox"/> Office building, etc.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-64</i> , to <i>10-18-68</i> , that (I) (we) last saw the deceased alive on <i>10-18-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James G. Saffell MD</i>		22c. DATE SIGNED <i>10-19-68</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Reisterstown, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 21, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Gilead</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Co. Md.</i>			
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>					ADDRESS <i>Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type in print) <b>12095 Lisa Ann Mrak</b>						2a DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>1968</b>			2b HOUR <b>11:30</b> A.M.			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>10/26/68</b>			6 AGE (In years lost birthday) YRS. MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md					
10. CITY OR TOWN OF DEATH <b>Towson</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>N/A</b>			12b KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE <b>Maryland</b>			13b COUNTY <b>Baltimore</b>			13c CITY OR TOWN <b>Reisterstown</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>29 Chestnut Hill Lane</b>		
14 FATHER'S NAME First Middle Last <b>Robert Mrak</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Dianne B. Bull</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT Address						
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <b>Immaturity</b>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from <b>10/26/</b> , 19 <b>68</b> , to <b>10/26/</b> , 19 <b>68</b> , that I (we) last saw the deceased alive on <b>10/26/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <i>Young Ho Yu, M.D.</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10/26/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Young Ho Yu, M.D.</b>						22e ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>						
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE <b>11/19/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Maryland</b>			23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24 FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REG. STAR DATE <b>NOV 21 1968</b>			25b REGISTRAR'S SIGNATURE <i>William J. ...</i>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

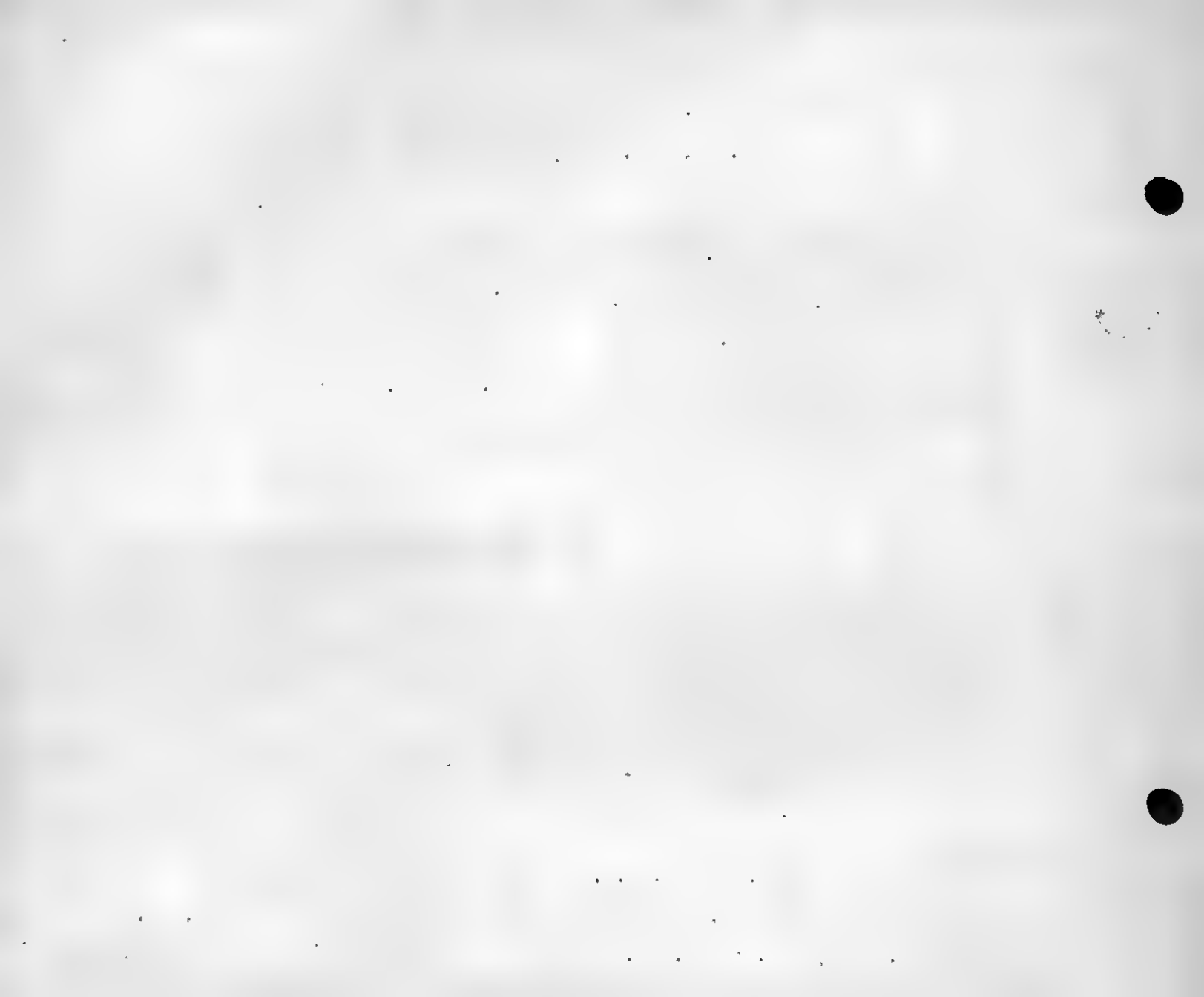
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14096

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14105

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b HOUR
JOHN D. MUHLY									10	5	1968	4:00pm
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	Min	2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	Sept. 14, 1968	3 wks					Month Day Year			8:40pm	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md			
Maryland		USA					Balto.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
Towson			St. Joseph Hospital			None						
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Md.			Baltimore			Balto.			702 Hollen Rd.			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
Kent F. Muhly			Carelyn Conkling									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			None			Mr. Kent F. Muhly			(Same)			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis (SDII)</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
7130												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			Edward F. Wilson, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			October 6, 1968			
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			10/8/68.			Holy Redeemer Cemetery			Baltimore, Md.			
24. FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REGISTRAR			
Leonard J. Ruck, Inc. Balto. Md. 21214									OCT 8 1968			
									25b REGISTRAR'S SIGNATURE			
									Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14097

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14106

1. DECEASED-NAME (Type or print) <b>EDNA W. MURAWSKI</b>			2a. DATE OF DEATH Oct. Month <b>31</b> Day <b>68</b> Year		2b. HOUR <b>4:45 PM</b>
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>11/5/1899</b>		6. AGE (In years lost birthday) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Cleveland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Chesapeake Manor</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Timonium</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>306 W. Timonium Rd.</b>
14. FATHER'S NAME First Middle Last <b>Fred W. Amsberg</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lena Gutricka GUTCHUECH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>273-01-6848</b>		17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INANITION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED LYMPHOBLASTOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>11 YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>2021</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>2/7</b> , 19 <b>67</b> , to <b>10/31</b> , 19 <b>68</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10/30</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
22b. SIGNATURE <b>Donald L. Somerville, M.D.</b> DEGREE				22c. DATE SIGNED <b>10/31/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DONALD L. SOMERVILLE, M.D.</b>				22e. ADDRESS <b>25 W. PA. AVE. TOWSON, MD 21204</b>	
23a. BURIAL CREMATION, REMOVA. (Specify) <b>Burial</b>		23b. DATE <b>Nov. 4, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Park</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>		23d. LOCATION (City or Town) (County) (State) <b>Cleveland, Ohio</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 1968</b>	
		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

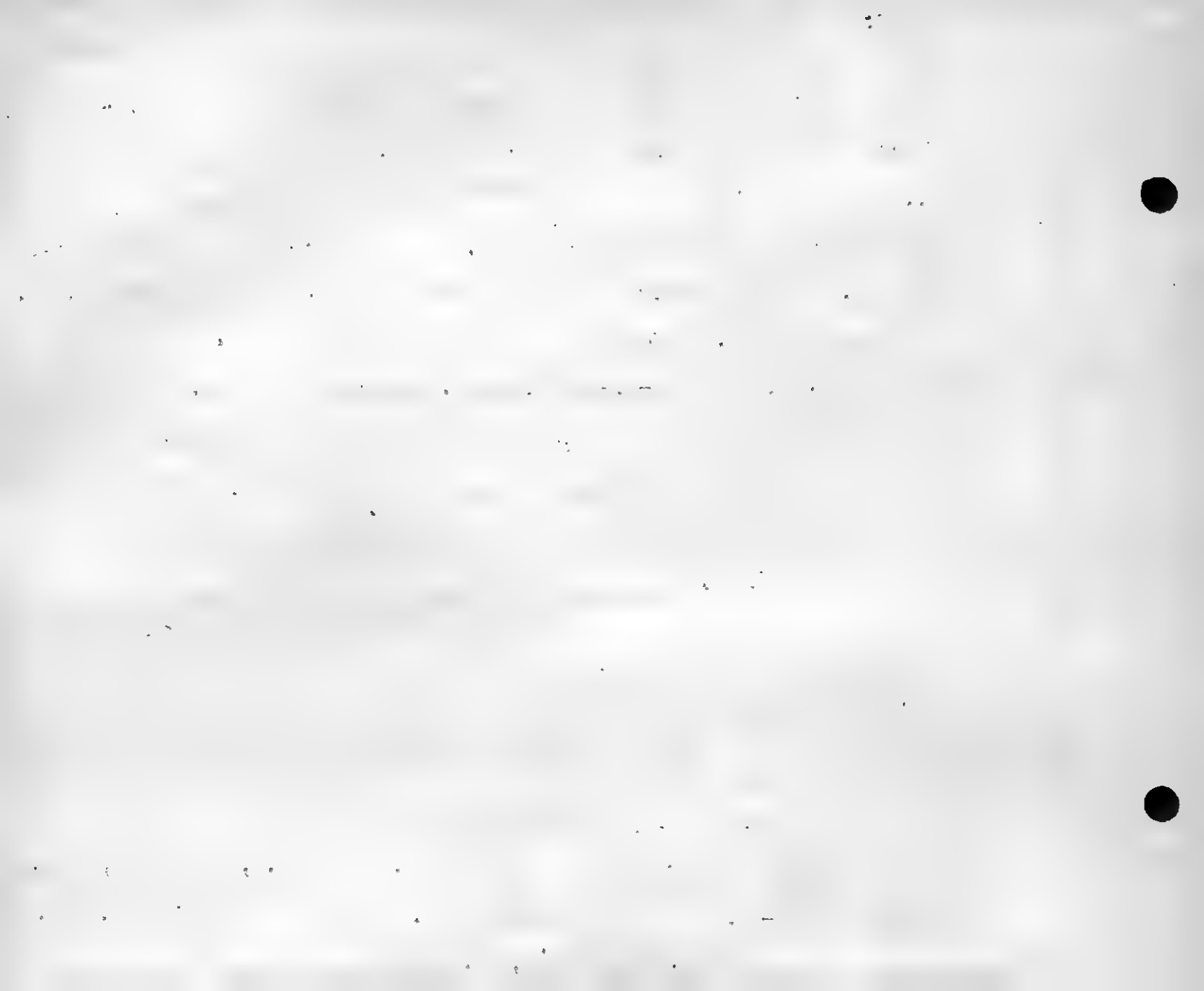




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>THOMAS</b>			First <b>THOMAS</b>			Middle <b>LEO</b>			Last <b>MURDOCK</b>		
2a. DATE OF DEATH <b>October</b> Month <b>6</b> , Day <b>1968</b>			2b. HOUR <b>12:30 P.M.</b>			3 SEX <b>Male</b>			4 RACE <b>White</b>		
5. DATE OF BIRTH <b>October 31, 1891</b>			6 AGE (In years last birthday) <b>76</b> YRS.			IF UNDER YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10 CITY OR TOWN OF DEATH <b>Bowleys Quarters</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Box # 127 Bengies Rd.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Storekeeper</b>		
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c CITY OR TOWN <b>Bowleys Quarters</b>			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER <b>Box # 127 Bengies Rd. #26.</b>			14 FATHER'S NAME First <b>James</b>			Middle <b>E.</b>			Last <b>Murdock</b>		
15 MOTHER'S MAIDEN NAME First <b>Dora</b>			Middle <b>E.</b>			Last <b>Cooke</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name or unknown) (If yes give year or date of discharge) <b>Yes W.W.I.</b>		
16b SOCIAL SECURITY NO <b>219-30-6621</b>			17 INFORMANT <b>Henry S. Murdock</b>			Address <b>Same.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis C.V. Disease</b> CONDITIONS if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Diabetes Mellitus</b> (b) <b>4-5-67</b> (c) <b>4-5-67</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10-6-68</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>None</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, natty medical Examiner) <b>None</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>None</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <b>None</b>							
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at home <b>None</b>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. <b>None</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>None</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>4-5-67</b> , 19 <b>1968</b> , to <b>10-6-68</b> , that (I) (we) last saw the deceased alive on <b>10-6-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>E. G. Schimunek</b>										22c DATE SIGNED <b>10-7-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>EMANUEL A. SCHIMUNEK</b>										22e ADDRESS <b>842 S. East Ave., Baltimore, 21224, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-9-68.</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>				23d. LOCAT ON (City or Town) (County) (State) <b>4300 Old Frederick Rd., Md.</b>			
24 FUNERAL DIRECTOR <b>Charles S. Guler</b>		ADDRESS <b>6224 Eastern Ave. Baltimore, 21224, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14108

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
RICHARD C. O'CONNELL						OCTOBER 19, 1968			7:10 P.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. COUNTY OF DEATH		
MALE		WHITE		DEC. 22, 1891		76 YRS		TOWSON, BALTIMORE		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
MARYLAND		U.S.A.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON 4			ST. JOSEPH HOSPITAL			Retired-Supervisor			Transportation	
13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13a. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			BALTIMORE		TOWSON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		238 Burke Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Charles T. O'Connell			Frances B. Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes WWI & WWII			214-40-5536		Mrs. Ona B. O'Connell (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal obstruction</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>carcinoma of colon with distant metastasis.</u>										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
1201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
10/16/68			Intestinal obstruction			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (a) (this hospital) attended the deceased from <u>OCT. 16, 1968</u> to <u>OCT 19, 1968</u> , that (we) last saw the deceased alive on <u>OCTOBER 19, 1968</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (not) view the body after death.										
22b. SIGNATURE <i>Christina Feliciano</i> , M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED OCT. 19, 1968		
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M. D.						22e. ADDRESS 7620 YORK RD. TOWSON 4, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			10/22/68		Baltimore National		Baltimore		Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.						25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



CERTIFICATE OF DEATH

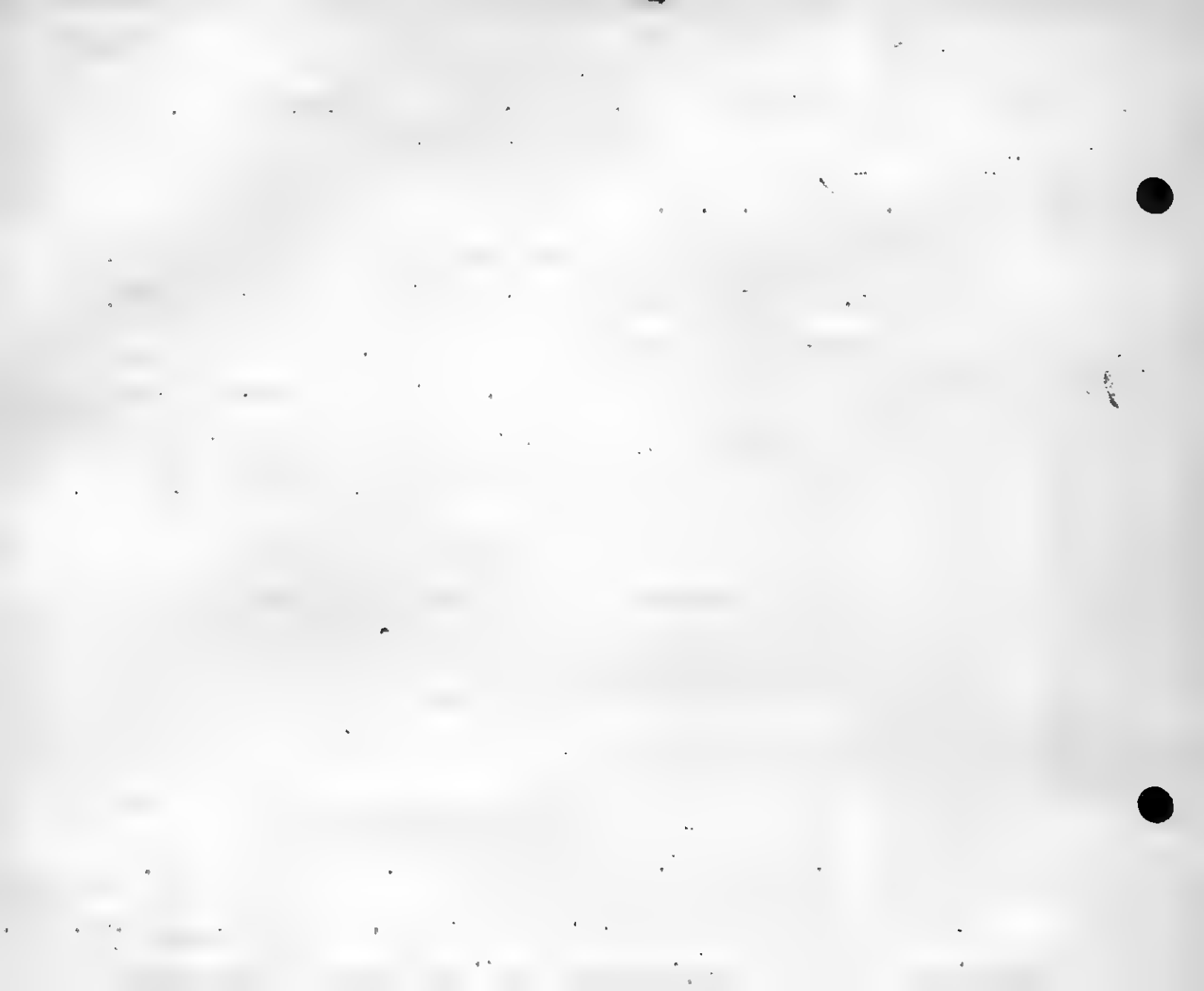
14100

14109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) <b>Wallace W. Oles</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR M			
3 SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH <b>7/23/1905</b>		6 AGE (in years last birthday) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>Conn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b> Md.			
10 CITY OR TOWN OF DEATH <b>Ruxton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1608 Ruxton Road</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired- Sales</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Envelope</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Ruxton</b>		13d INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1608 Ruxton Road</b>	
14 FATHER'S NAME First Middle Last <b>Burdette Oles</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>V. Viola</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII</b>		17 INFORMANT Address <b>Mrs. Natalie Webb Oles (Same)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4:1:1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>44</b> , to <b>Oct</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Sept 13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>RK Gundry</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>10-7-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Richard K. Gundry</b>				22e. ADDRESS <b>2 W. University Pkwy.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville, Balto. Co., Md.</b>			
24 FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14101

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14110

1 DECEASED-NAME (Type or Print) <i>Ronald</i> First <i>C.</i> Middle <i>Owings</i> Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Oct.</i> Day <i>3</i> Year <i>68</i> 19			2b. HOUR <i>4:50</i> P.	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 14, 1949</i>		6. AGE (In years last birthday) <i>19</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Balto. City</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>	
10. CITY OR TOWN OF DEATH <i>Reisterstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>117 1st Ave.</i>			12a. USUAL OCCUPATION (Kind of work done) <i>Maryland Paper Cup Company</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <i>Clinton</i> Middle <i>R.</i> Last <i>Owings</i>			15. MOTHER'S MAIDEN NAME First <i>Delores</i> Middle <i>E.</i> Last <i>Mitchell</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO <i>218-54-2706</i>		17. INFORMANT <i>Mr. Clinton R. Owings</i> ADDRESS <i>Reisterstown, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gunshot wound head</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>10/5/68</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>to 3</i>			21b. TIME OF INJURY Month, Day, Year <i>9</i> HOUR A.M. <i>Oct. 3</i> P.M. <i>68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>self inflicted</i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No <i>117 1st Ave.</i> City or Town <i>Reisterstown</i> County <i>Balto.</i> State <i>Md.</i>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D. D. Caples</i>		EXAMINER'S NAME (Type) <i>D. D. Caples, M. D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>10-4-68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>		23d. LOCATION (City or Town) <i>Reisterstown, Md.</i> (County) (State)	
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i> ADDRESS <i>Reisterstown, Md.</i>				25a. REC'D BY REGISTRAR <i>OCT 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



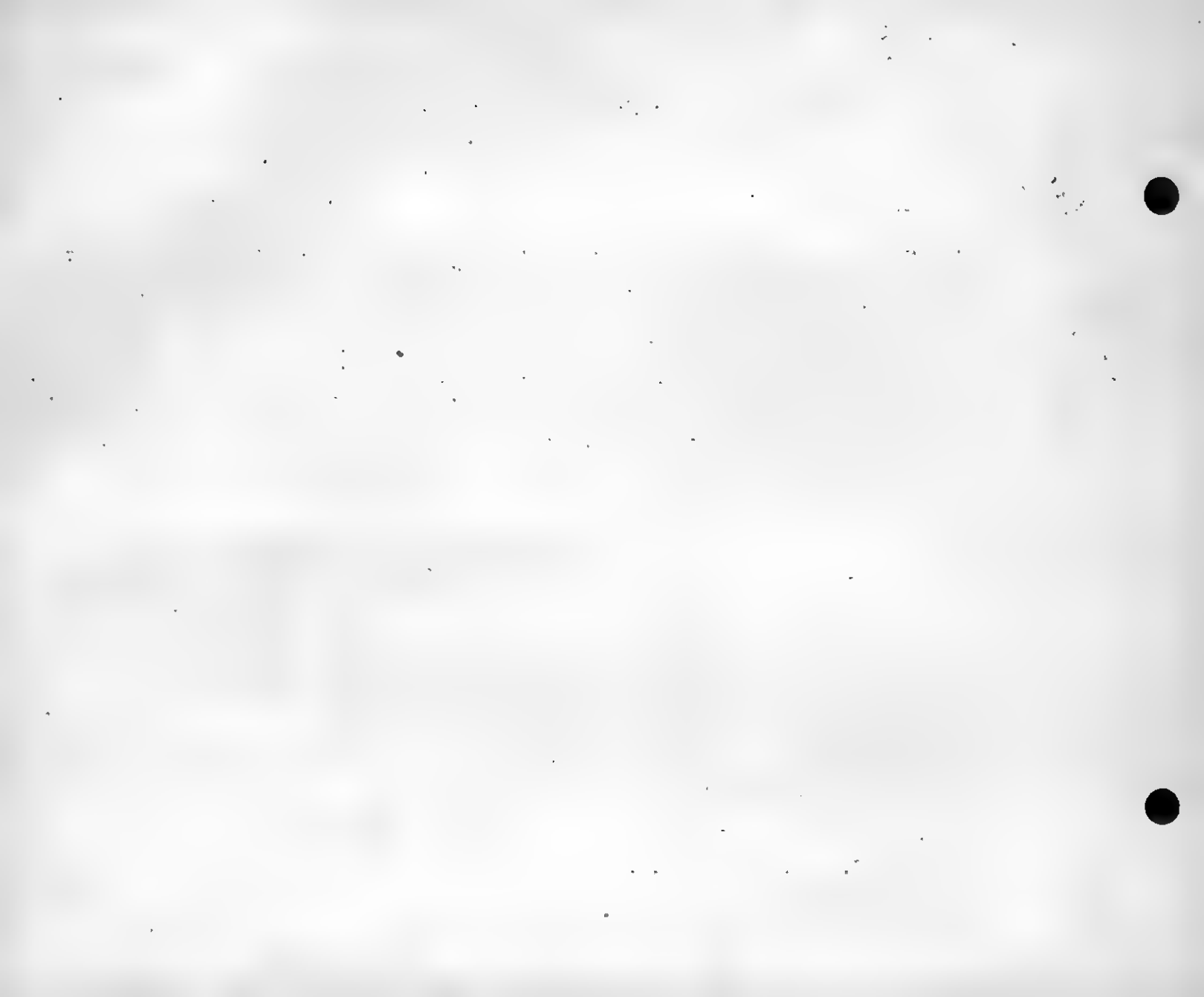


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 13 Film 465 7-1-68												
1 DECEASED NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year		2b. HOUR
MARY Marcella Padian										10 12 68		11:20A.M.
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
F	W		6/12/1880			58 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
BALTIMORE			U.S.A.						BALTIMORE Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON			STELLA MARIS Hospice			Housewife			NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MD.			BALTIMORE			Balto.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			
DANIEL J. FIELDING			LAURA HINDER.			NO			NONE			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			17b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
NO			NONE			STELLA MARIS Hospice Inc.			TOWSON MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Delusional CVA</u> <u>4107</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last 4/2/21</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>chronic</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of the breast</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>7-26</u> , 19 <u>68</u> , to <u>10-12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			
<u>[Signature]</u>			10-12-68			J. David Nagel, M.D.			812 Mockingbird Lane			
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Oct. 15, 1968			Mt. Marie Cemetery			Towson, Maryland			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
John Burns & Sons			OCT 18 1968			Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
141108 Items 5 & 6 Film 406 10/30/68 kk										
141112										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Florence			L. Page			Oct 21 68		4:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
Female		White		5-30-94 1895		73 1/2 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
W. Va		USA				Baltimore,		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown			3401 Old Court Rd.			house wife				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Balto		Jwin's Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Ex 233 Lyons Mill Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
James Whittington			?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No			220-03-9185 B		James N. Page		3506 St. James Rd. Balto. 07			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) B. lateral Bronchopneumonia										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Congestive Heart Failure										
DUE TO, OR AS A CONSEQUENCE OF										
Arteriosclerotic Heart Disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4129										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION					
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/19, 1968, to 10/21, 1968, that (I) (we) last saw the deceased alive on 10/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Gregorio Hearsh									10/21/68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10/24/68		Druid Ridge Cemetery		Pikesville Balto. Co. Md.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Loring Byers 8728 Liberty Rd. Randallstown							OCT 24 1968		Charles Judge	



## CERTIFICATE OF DEATH

14113

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P	
Gregory				Palmieri	October 20, 1968		1:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		12-21-1894		73 YRS.		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Italy		U. S. A.				Baltimore Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph		retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		--		Baltimore				248 S. Robinson St. #21224
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Paul		Palmieri						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO		214-01-0761A		Mr. Paul Palmieri				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>								
5111 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Uremic Poisoning</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
5111								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from <u>Oct. 13</u> , 1968, to <u>October 20</u> , 1968, that (A) (we) lost saw the deceased alive on <u>October 20</u> , 1968, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
Jaime Punzalan		10/20/68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Jaime Punzalan, M.D.		7620 York Rd. #21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		10/23/68		Holy Redeemer		Baltimore Md		
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Joseph W. Zanner Jr		OCT 21 1968		J. Carlos Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14105

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14114

1. DECEASED-NAME (Type or Print)			First ABNER			Middle PERRY			Last PERRY			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10/28 1968			2b. HOUR 5:55 P.M.						
3 SEX male		4. RACE white		5 DATE OF BIRTH 9-28-21		6 AGE (in years last birthday) 47 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year October 28, 1968			2d. HOUR 6:57 P.M.						
7a BIRTHPLACE (State or foreign country) N.C				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore Md.									
10. CITY OR TOWN OF DEATH Baltimore (Lansdowne)						11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) B & O Tracks - N. of Clyde						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic				12b KIND OF BUSINESS OR INDUSTRY Auto					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission to State) Maryland						13b. COUNTY Baltimore						13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 833 Woodward Street					
14 FATHER'S NAME First Middle Last Augustus Perry						15 MOTHER'S MAIDEN NAME First Middle Last Laura ?Gardner															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes						16b SOCIAL SECURITY NO 1939-1945 565 34 6298						17 INFORMANT Mrs. Margaret Perry 433 Woodward St. 21230									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries 8059 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 802 X																					
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? XXXX NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b TIME OF INJURY Month, Day, Year HOUR MIN 5:55 P.M. 10/28 1968						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) subj. was struck by a train									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) railroad tracks						21f LOCATION Street or R.F.D. No City or Town County State Baltimore, Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)						22b DATE SIGNED 10/29/68									
23a BURIAL, CREMATION, REMOVAL				23b DATE 11-1-68				23c NAME OF CEMETERY OR CREMATORY Balto. National				23d LOCATION (City or Town) (County) (State) Balto. Md.									
24 FUNERAL DIRECTOR Johnson Funeral Home 8521 Loch Raven Blvd.						ADDRESS 21204						25a REC'D BY REGISTRAR DATE NOV 1 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge							





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

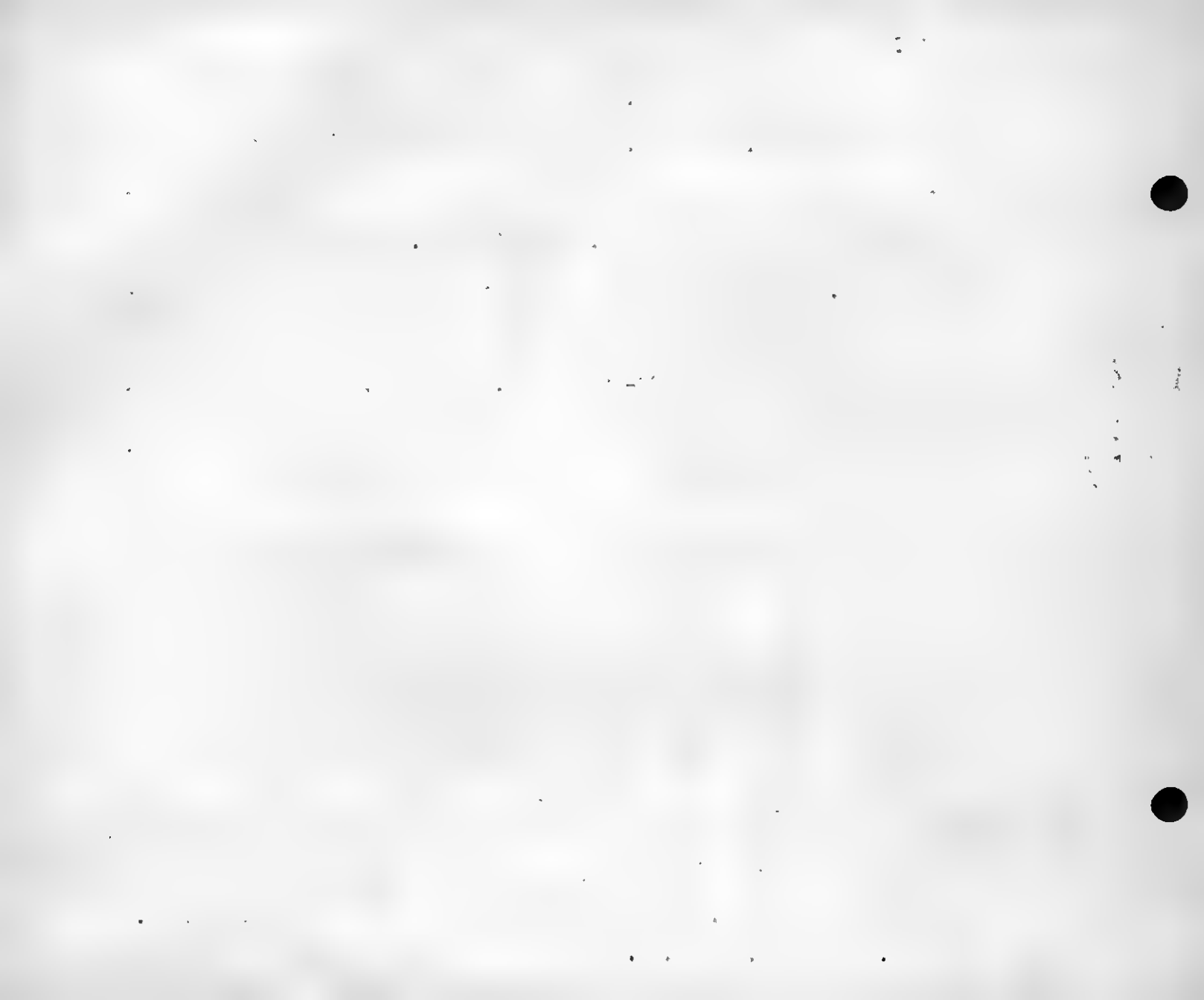
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11106

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14115

1 DECEASED-NAME (Type or Print)		First <b>WILLIAM</b>		Middle <b>H.</b>		Last <b>PLOCK</b>		2a DATE KNOWN OF DEATH ESTI MATED <b>October 5 1968</b>			2b HOUR: <b>7P</b> M	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Nov. 12, 1900.</b>		6 AGE (In years last birthday) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD <b>October 5</b> Year <b>1968</b> 2d HOUR: <b>7P</b> M		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CIT ZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md						
10. CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hosp.</b>				12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Plumber</b>				12b KIND OF BUSINESS OR INDUSTRY		
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>4613 Ridgeway Avenue</b>				
14. FATHER'S NAME First <b>Henry</b>		Middle <b>Plock</b>		Last <b>Plock</b>		15. MOTHER'S MAIDEN NAME First <b>Unknown</b>		Middle <b>Unknown</b>		Last <b>Unknown</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>212-22-4696</b>		17. INFORMANT <b>Mrs. Eleanor M. Plock</b>		ADDRESS <b>(Same)</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio Renal</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 yrs</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>427</b>												
19a. DATE OF OPERATION <b>10/9/68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Vehicle</b>								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/7/68</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>10/9/68.</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d LOCATION (City or Town) <b>Baltimore, Md.</b>		(County)		(State)		
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>						25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV.

<div style="display: flex; justify-content: space-between;"> <div> <p>141107</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>Item 10 Film 645-101107-2</p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>14116</p> </div> </div>											
1. DECEASED NAME (Type or print) <b>SIDNEY</b>				First Middle Last		2a. DATE OF DEATH Month Day Year <b>OCTOBER 2, 1968</b>			2b. HOUR <b>11 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 2, 1922</b>			6. AGE (In years last birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>HAGERSTOWN, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3416 MERLE DRIVE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>DRAPERY</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3416 MERLE DRIVE</b>	
14. FATHER'S NAME First Middle Last <b>FRANK POLLACK</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA ?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give year or dates of service) <b>W.W. II</b>				16b. SOCIAL SECURITY NO		17. INFORMANT Address <b>MRS. ROSE POLLACK, 3416 MERLE DRIVE #21207</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immersed 5 yrs 10 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260A</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 30, 1968</b> to <b>Oct 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 30, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Irvin Sauber</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>IRVIN SAUBER</b>						22e. ADDRESS <b>6905 PARK HEIGHTS AVENUE</b>					
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-XX 4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>AGUDAR BNAI JACOB LODGE</b>				23d. LOCATION (City or Town) (County) (State) <b>ROSEDALE, MARYLAND</b>			
24. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal. 3 and 4 in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1 68

15103

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14117

1. DECEASED NAME (Type or Print) <b>Joseph</b>		Middle		Last <b>Portney</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <b>10/13 1968</b>		2b. HOUR <b>5:30 A.M.</b>	
3. SEX <b>male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>6/25/04</b>	6. AGE (in years at birthday) <b>64 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>13</b> Year <b>1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		2d. HOUR <b>3:00 A.M.</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Baltimore Co. Gen. Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during life, even if retired) <b>FORMER DRIVER</b>		12b. KIND OF BUSINESS OR OCCUPATION <b>TAXI</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>3508 Langrehr Rd</b>	
14. FATHER'S NAME First <b>Nathan</b> Middle <b>Portney</b> Last <b>Milstein</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Milstein</b> Last <b>Milstein</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>[redacted]</b>		17. INFORMANT <b>Mrs. Ethel Portney - 3508 H Langrehr Rd.</b>		ADDRESS <b>[redacted]</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>10/13/68</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>22b. DATE SIGNED</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>1311 Francis Ave.</b> ADDRESS (Street, city, town, or county) <b>Baltimore Md. 21227</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Vincent's Cemetery</b>		23d. LOCATION (City or Town) <b>Baltimore, Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Ed. Leonard &amp; Sons Inc. 6010 Reisterstown Rd.</b>				25a. REC'D BY REGISTRAR <b>[redacted]</b>		25b. REGISTRAR'S SIGNATURE <b>[redacted]</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14102

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14118

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
EVELYN C. PRICE						Month Day Year			10 4 1968		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Female	White	Feb. 13, 1907	61 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			1:57 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Balto. Md					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Retired Cashier			N.R.S.		
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.						Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2311 Carrille Ave. 21214	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Joseph Wright			Christina Duvall								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			214-01-5446			Mr. Tully A. Price			(Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u>											
4120 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
443X											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b. DATE SIGNED					
			Edward F. Wilson, M.D.			October 5, 1968					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial			10/5/68.		Parkwood Cemetery		Baltimore, Md.				
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Balto. Md. 21214						OCT 8 1968					



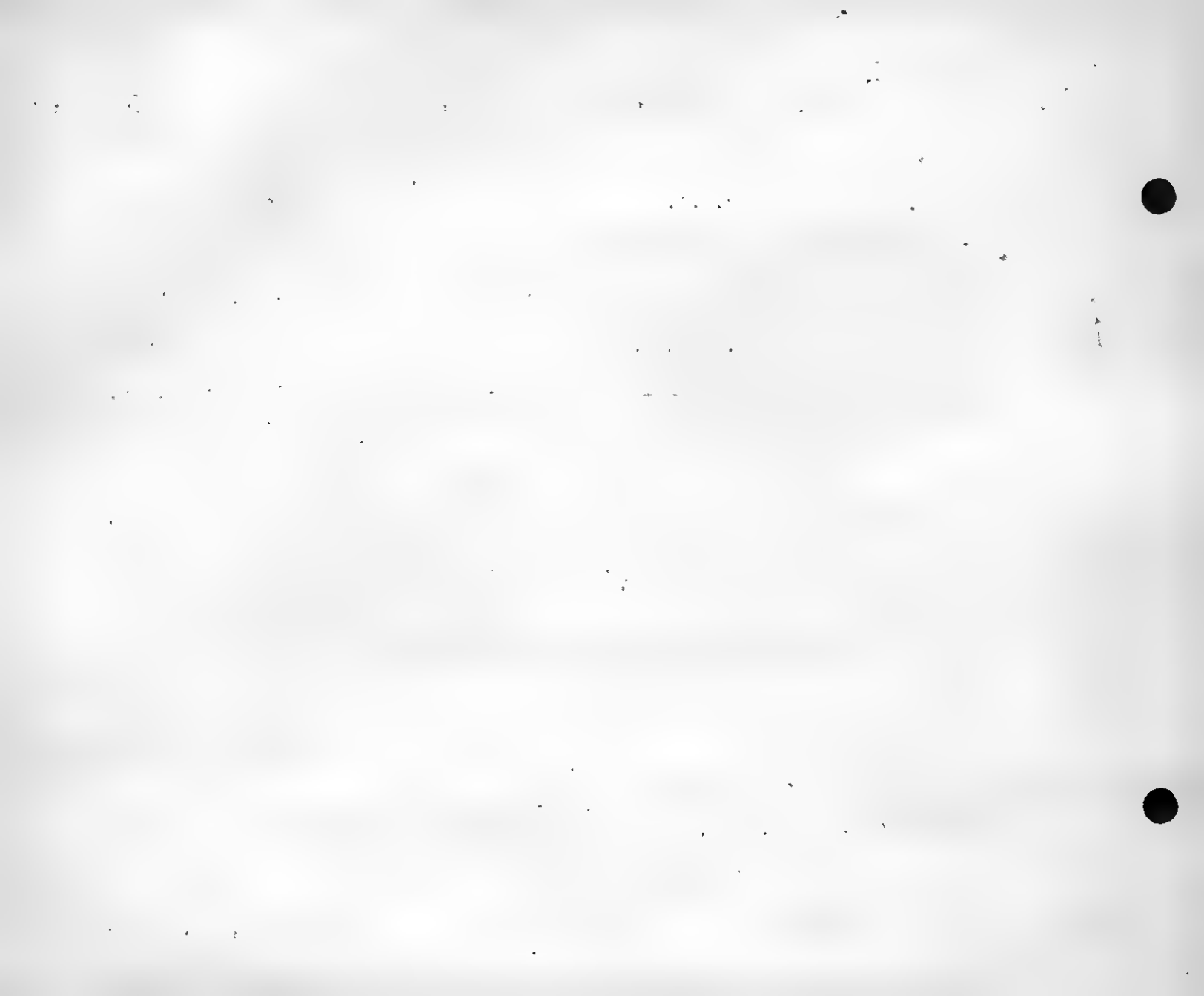


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV 1-68

14110										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14119																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Mary Shelia Puffenbarger										Month Day Year 10 3 68										5:35 PM																													
3. SEX Female										4. RACE White										5. DATE OF BIRTH 8-31-52										6. AGE (In years lost birthday) 16 YRS.										7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md																			
10. CITY OR TOWN OF DEATH Owings Mills										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dependent										12b. KIND OF BUSINESS OR INDUSTRY none																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. CITY OR TOWN Montgomery										13c. INSIDE CITY (If 157) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 11915 Center Hill Street																			
14. FATHER'S NAME First Middle Last Norval J. Puffenbarger										15. MOTHER'S MAIDEN NAME First Middle Last Lucille Hodge										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no										16b. SOCIAL SECURITY NO. ---										17. INFORMANT Address Rosewood's Records Owings Mills, Md. 21117									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 341X Multiple Decubital ulcers (Buttermaier) (b) Progressive degenerative disease. (c) (Schneider's) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Mos. 10 yrs.										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Schneider's disease 10 yrs.																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (X) (this hospital) attended the deceased from 4/4, 1967, to 10/3, 1968, that (X) (we) last saw the deceased alive on 10/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.										22b. SIGNATURE Harry G. Butler MD. DEGREE HARRY G. BUTLER										22c. DATE SIGNED 5 Oct 68																													
22d. PHYSICIAN'S NAME (Type) HARRY G. BUTLER										22e. ADDRESS																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 10/7/68										23c. NAME OF CEMETERY OR CREMATORY Parklawn										23d. LOCATION (City or Town) (County) (State) Rockville, Montg. Maryland																			
24. FUNERAL DIRECTOR Tyson Wheeler funeral Home										25a. REC'D BY REGISTRAR 1991 Rock. Pike Rockville, Md.										25b. REGISTRAR'S SIGNATURE Charles Judge										DATE OCT 8 1968																			



## CERTIFICATE OF DEATH

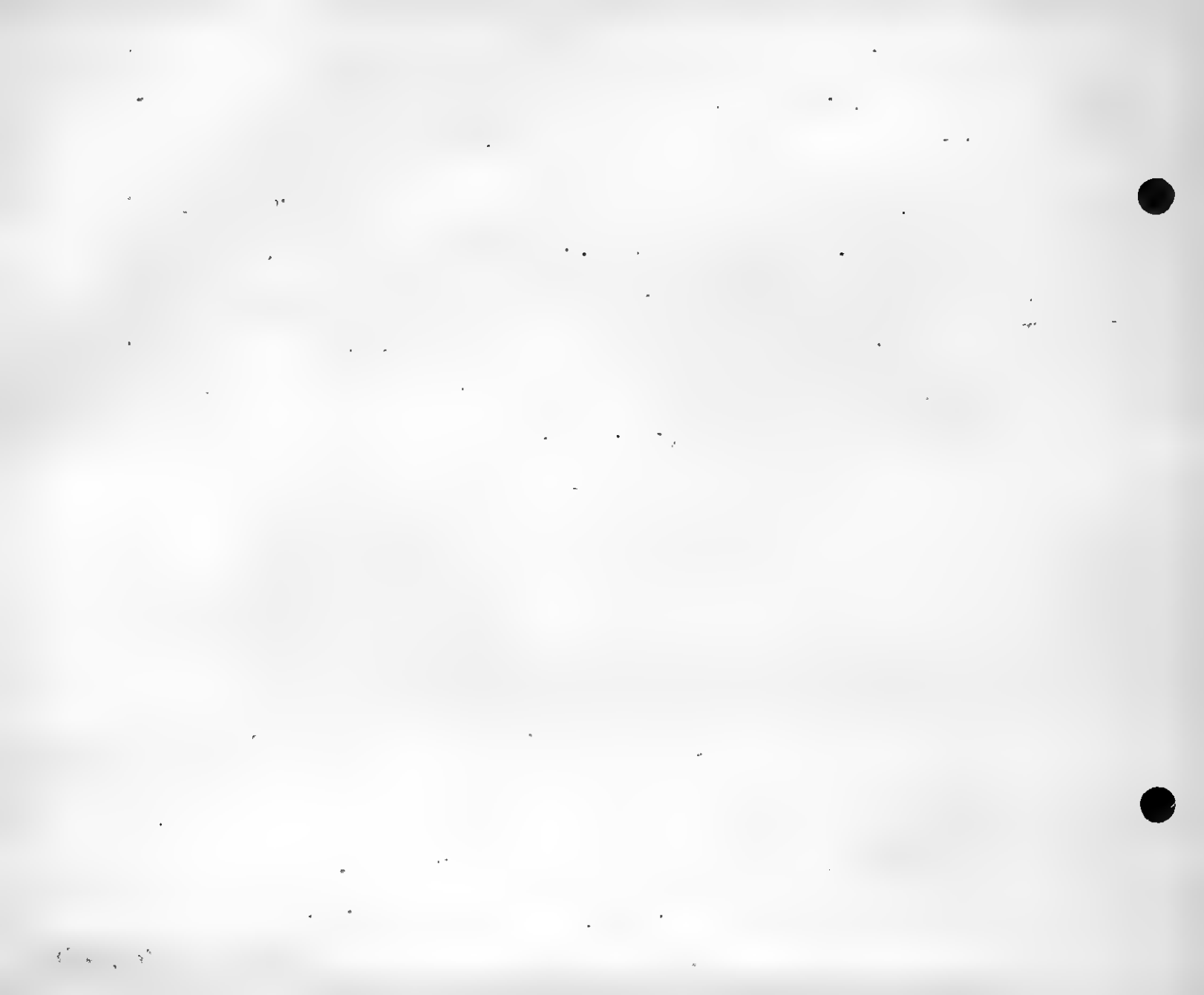
14111

14120

1 DECEASED-NAME (Type or print) <b>FRANK NMN QUERCIA</b>			2a. DATE OF DEATH 10 Month 02 Day 68 Year			2b. HOUR 5 A M						
3 SEX <b>MALE</b>		4 RACE <b>CAU</b>		5. DATE OF BIRTH <b>3-18-81</b>		6. AGE (In years last birthday) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE CO.</b> Md.						
10. CITY OR TOWN OF DEATH <b>TOWSON, MD.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GRTH. BALTO. MED. CENTER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Chef</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if in institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8013 Ridgely Oak Rd</b>			
14. FATHER'S NAME First Middle Last <b>Dominic Quercia</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Teresa DeVanno</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Teresa Powell</b> Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>5534</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HEART INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>INCARCERATED HERNIA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC			21f. LOCATION Street or RFD No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>9-26</b> , 19 <b>68</b> , to <b>10-02</b> , 19 <b>8</b> , that (I) (we) last saw the deceased alive on <b>10-02</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Dr. F. Naeim</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10-02-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. FARAMARZ NAEIM</b>						22e. ADDRESS <b>G.B.M.C.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10/5/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St John's</b>			23d. LOCATION (City or Town) (County) (State) <b>Brooklyn New York</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc Baltimore, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 2 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

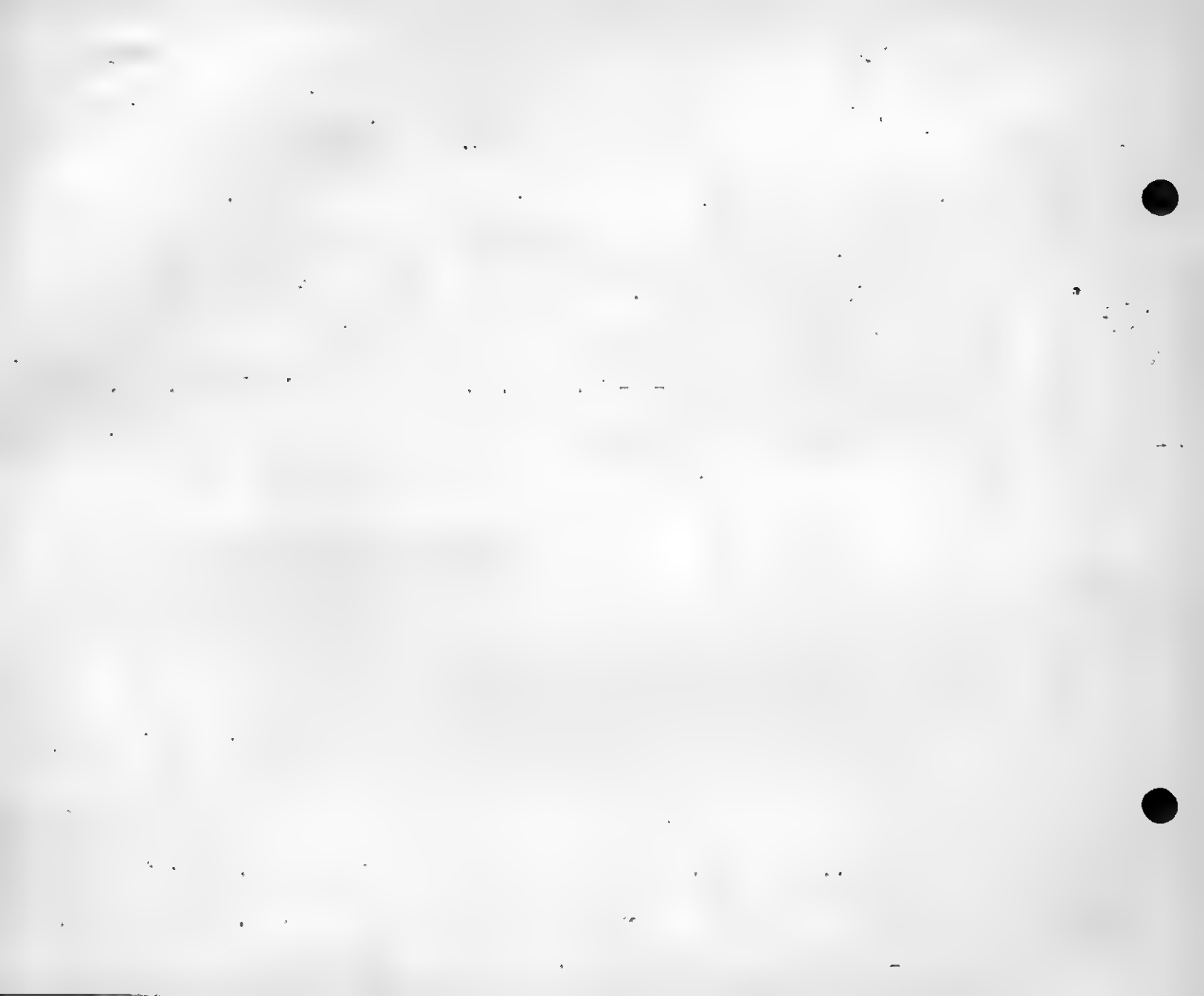
14112

14121

1. DECEASED-NAME (Type or print) <b>Catherine</b>			First Middle Last			2a. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1968</b>			2b. HOUR <b>11:55 P M</b>		
3 SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Dec. 18, 1880</b>			6 AGE (in years last birthday) <b>87</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore Co.</b>		
10. CITY OR TOWN OF DEATH <b>Upper Falls, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bradshaw Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of work ng. life, even if retired.) <b>former music teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Upper Falls</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>Bradshaw Road</b>			14. FATHER'S NAME First <b>Lorenz</b> Middle <b>Krieger</b> Last <b>Catherina</b>			15. MOTHER'S MAIDEN NAME First <b>Catherina</b> Middle <b>Lassiter</b> Last <b>642 Charles St. Ave. #21204</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO <b>217-52-7702</b>			17 INFORMANT <b>E. B. Lassiter</b>			Address <b>642 Charles St. Ave. #21204</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized arteriosclerosis, senility</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/10, 1967</b> , to <b>10/31, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/31, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Phyllis K. Pullen M.D.</b>						DEGREE <b>DEGREE</b> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>11/1/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Phyllis K. Pullen</b>						22a. ADDRESS <b>Box 381 Jerusalem Rd, Kingsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>entombment</b>			23b. DATE <b>11/2/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Mausoleum</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home 6500 York Rd. #21212</b>						25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers ~~pages~~ 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

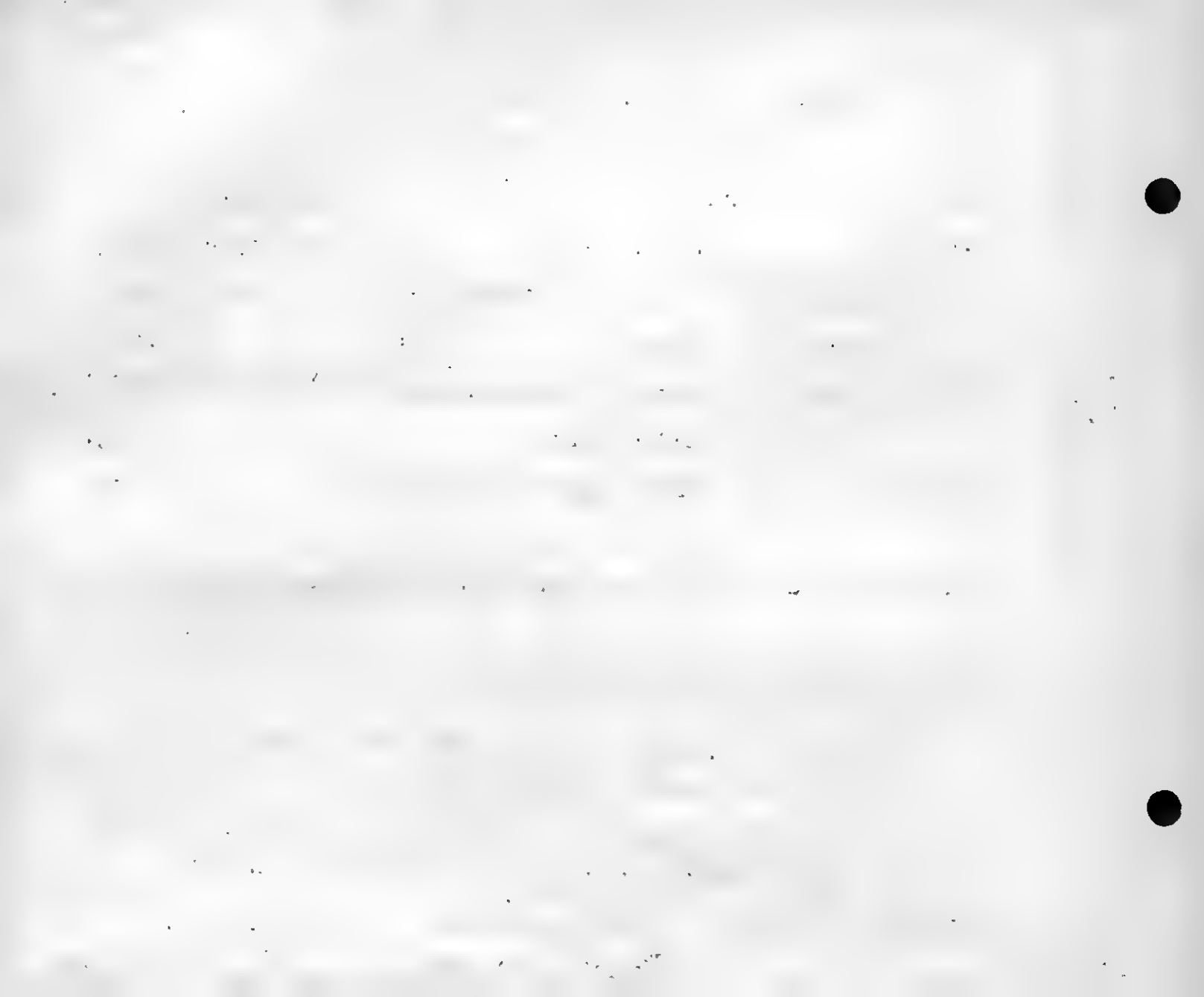
14113

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14122

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>CHARLES</b>		First <b>J.</b>	Middle <b>RANKE</b>	Lost	2a DATE OF DEATH Month <b>10</b> Day <b>4</b> Year <b>68</b>			2b HOUR <b>2:30AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5/24/91</b>		6. AGE (In years last birthday) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md.			
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. AM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during part of work life, even if retired) <b>SHEET METAL WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3916 Dudley Avenue</b>	
14. FATHER'S NAME First <b>HERMAN</b>		Middle <b>RANKE</b>		Lost		15. MOTHER'S MAIDEN NAME First <b>MARY</b>		Middle <b>GREENWALD</b>	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b>		(If yes give war or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO. <b>216 05 61 31</b>		17. INFORMANT <b>Mary Ranke (Nee Szebenely) above, wife</b> <b>CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL EDEMA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>237X</b> (b) <b>BRAIN TUMORS, TYPE UNDETERMINED</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>  <b>OLD</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ARTERIOSCLEROTIC HEART DISEASE, OLD. PULMONARY EMPHYSEMA MARKED, OLD</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>(he)</del> (this hospital) attended the deceased from <b>10/3/68</b> , 19__, to <b>10/4/68</b> , 19__, that <del>(he)</del> (we) lost the deceased alive on <b>10/4/68</b> , 19__, and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(he)</del> (we) (did) <del>(not)</del> view the body after death.									
22b. SIGNATURE <i>John D. Talbert, MD</i>				DEGREE <b>MD</b>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/4/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>				22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>			
24. FUNERAL DIRECTOR		ADDRESS <b>SCHIMUNEK FUNERAL HOME</b>		25a. RECEIVED BY REGISTRAR <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 157M  
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14114											
14123											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Elizabeth Ann Reed						Month Day Year October 29, 1968			4:45 a. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		Nov. 19, 1888		79 YRS		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Delaware		U. S.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			housewife - School Board					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.			Balto.			Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2704 Taylor Avenue	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
James Grimes				Susan ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT Address					
No			214-26-9273			Records: SPRING GROVE STATE HOSPITAL					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 1109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from May 2, 1968, to Oct. 29, 1968, that (X) (we) last saw the deceased alive on Oct. 29, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Anthony J. Young, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			10-29-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Spring Grove State Hospital						Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			11/1/68.			Parkwood Cemetery			Baltimore, Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Balto. Md. 21214						DATE OCT 30 1968			Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14115		CERTIFICATE OF DEATH						14124	
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Sophia			C.		Reider	10 23 1968			
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		Cau.		12-9-1900		67 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
Balto. Co.		U.S.A.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Rural Haspeburg			407 Babikow Road			Cafateria Worker		Martins	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.			Baltimore						407 Babikow Road 6
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John					Bartenfelder	Elizabeth			Becker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			216-20-4642		Dorothy R. Neely		8401 Hallmark Circle 34		
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 15% DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
157X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
July 1967			Carcinoma of Pancreas						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter not use of injury in Part I or Part 2, Item 18)				
			19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>7/24/1968</u> to <u>08/01/1968</u> , that (I) (we) last saw the deceased alive on <u>8/21/1968</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
Robert Roubenoff MD			10/24/1968			ROBERT ROUBENOFF			
						22e. ADDRESS			
						285 Ridge Rd 21206			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		10-26-1968		Moreland Cemetery		Baltimore		City	Md.
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Lassahn Funeral Home 7401 Belair Road 21236					DATE OCT 28 1968		J Charles Judge		

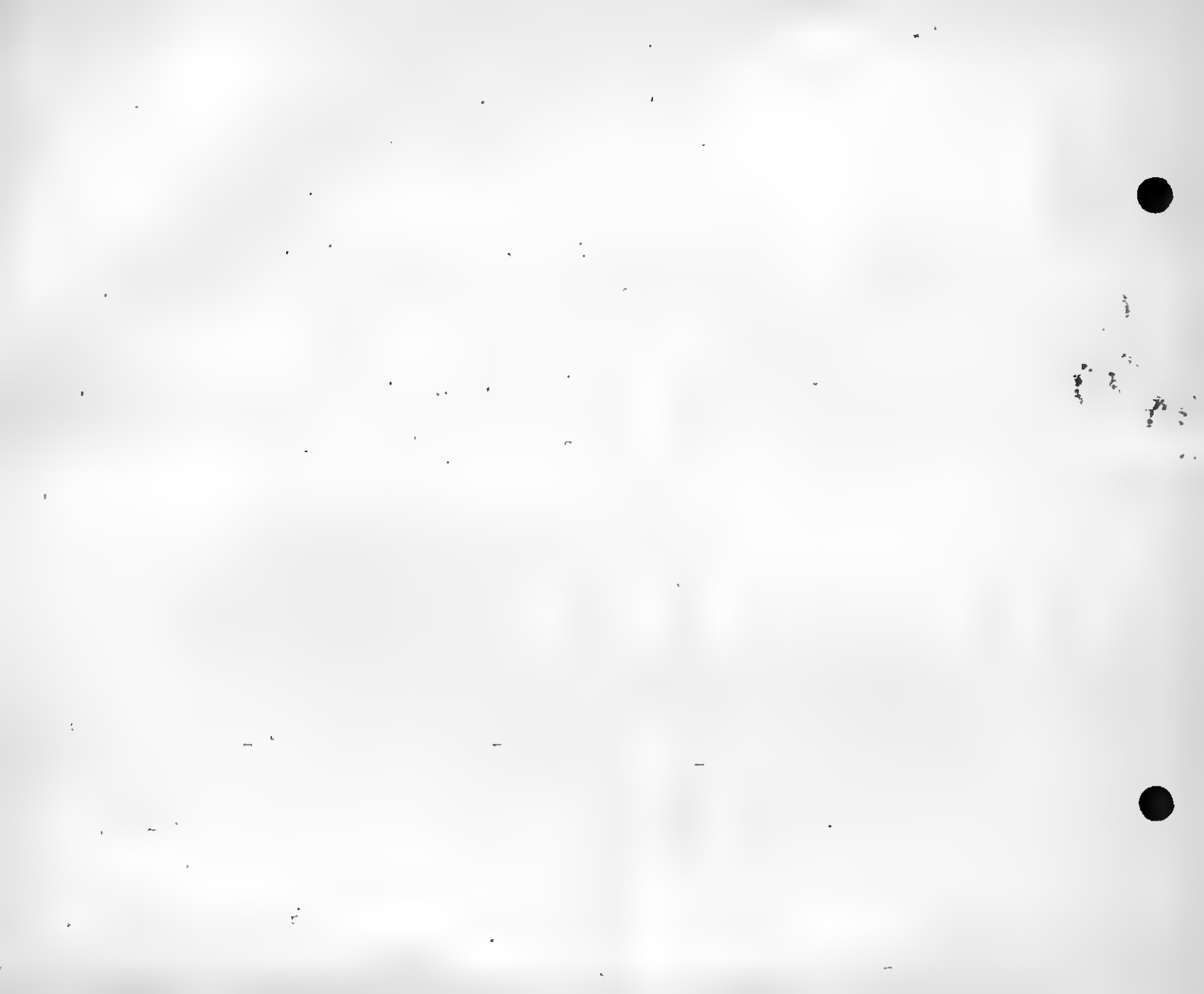


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515  
30M REV 11-68

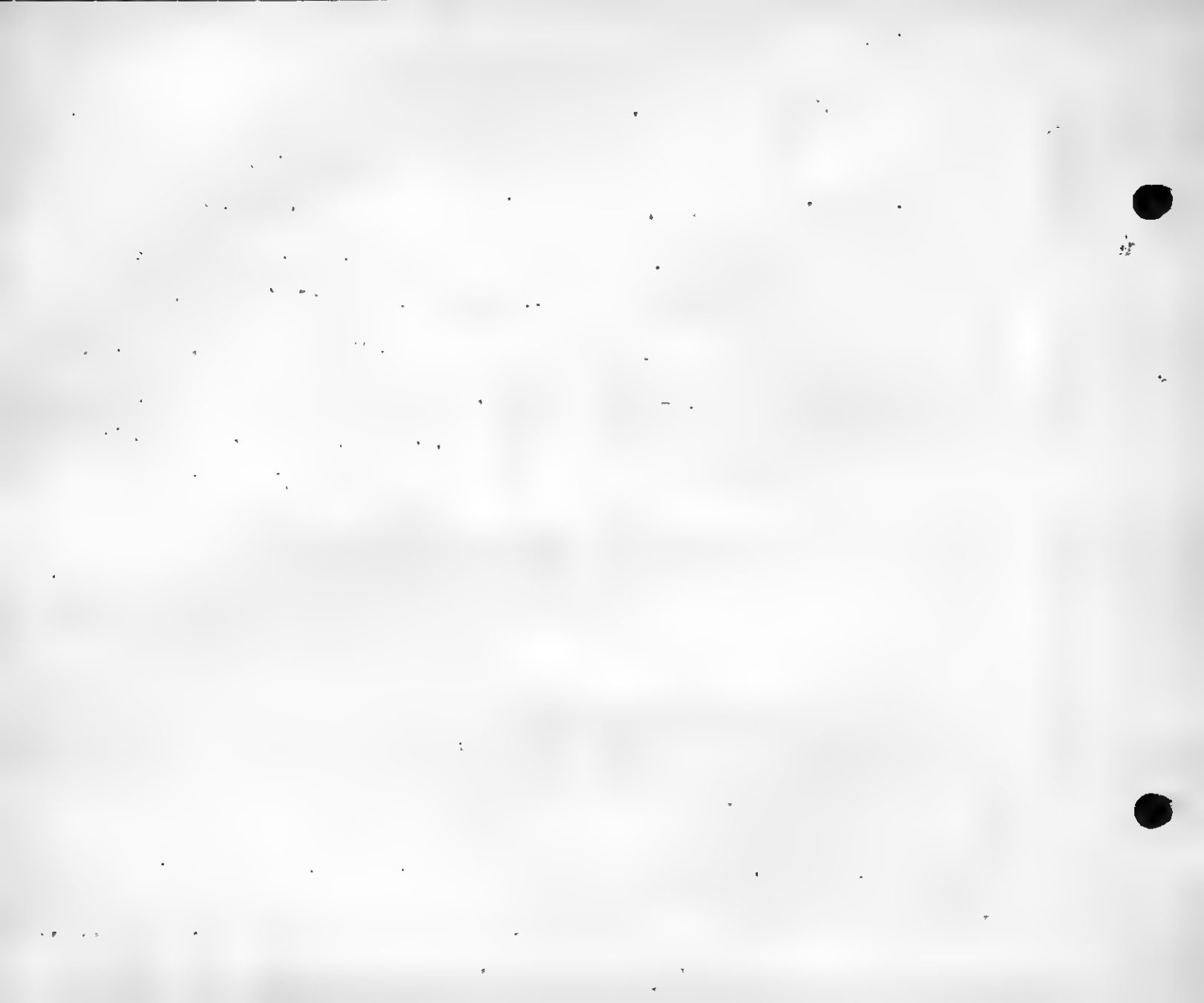
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
A.			Louise	Reinheimer		Oct. 7, 1968			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
female		white		Feb. 5, 1882		86 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. KIND OF BUSINESS OR INDUSTRY	
Maryland		USA				Baltimore		Md.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				13. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		14. KIND OF BUSINESS OR INDUSTRY	
Stoneleigh		500 Stoneleigh Rd.				housewife			
15a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		15b. COUNTY		16. CITY OR TOWN		17. INSIDE CITY LIMITS?		18. STREET AND NUMBER	
Maryland		Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		500 Stoneleigh Rd.	
19. FATHER'S NAME			First	Middle	Last	20. MOTHER'S MAIDEN NAME			First
Charles					Rose	Louise			
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			21b. SOCIAL SECURITY NO			22. INFORMANT			Address
no			213-20 8786			Arthur E. Reinheimer			500 Stoneleigh Rd. #12
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u> <u>10 Yrs.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>351X</u> <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> , 19 <u>66</u> , to <u>10-7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paul B. Herold, M.D.</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10-8-68</u>
22d. PHYSICIAN'S NAME (Type) <u>Dr. Paul Herold</u>					22e. ADDRESS <u>10 W. Madison St.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>10/10/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore County, Md.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd.</u> <u>Balto., Md. 21212</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14117										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14126									
1. DECEASED-NAME (Type or print) <b>William G. Rhodes</b>										2a. DATE OF DEATH <b>10</b> Month <b>25</b> Day <b>68</b> Year <b>3</b> 45 A M										2b. HOUR									
3. SEX <b>Male</b>					4. RACE <b>White</b>					5. DATE OF BIRTH <b>10/27/83</b>					6. AGE (In years last birthday) <b>84</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Baltimore</b> Md.														
10. CITY OR TOWN OF DEATH <b>Baltimore 21204</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Salesman</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Shoes</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>					13c. CITY OR TOWN <b>Baltimore</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>6105 York Road</b>									
14. FATHER'S NAME First <b>James</b> Middle <b>Rhodes</b> Last <b>Rhodes</b>					15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>S.</b> Last <b>Bennett</b>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <b>213-07-6202A</b>					17. INFORMANT <b>Mrs. Mae Rhodes</b> Address <b>(Same)</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4104 Acute myocardial infarct.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1 1/2 hr</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> , 19 <b>68</b> , to <b>10/25</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>10/25/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>John A. Mitchell</b>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>10/25/68</b>														
22d. PHYSICIAN'S NAME (Type) <b>JOHN A. MITCHELL</b>										22e. ADDRESS <b>ST. JOSEPH HOSPITAL</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>					23b. DATE <b>10/28/68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Mausoleum</b>					23d. LOCATION (City or Town) (County) (State) <b>Parkville, Balto. Co. Md.</b>														
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>										ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>					25a. REC'D BY REGISTRAR <b>OCT 25 1968</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

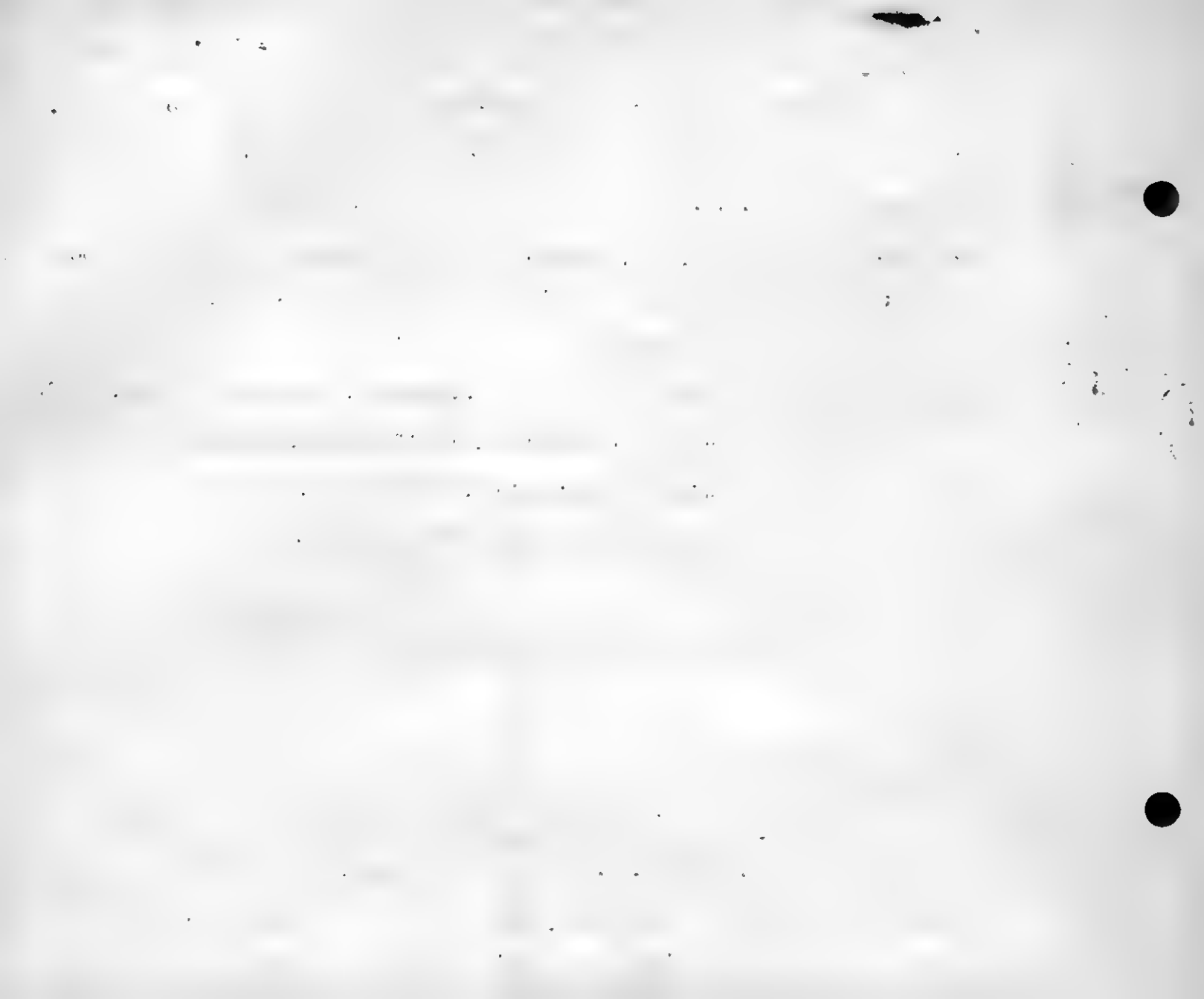
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14127

1. DECEASED NAME (Type or print) <b>AARON LEE RICHARDSON</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>68</b>			2b. HOUR <b>11:55 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>2/1/21</b>		6. AGE (In years last birthday) <b>47</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLAM SHUCKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SEA FOOD IND.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>QUEEN ANNE</b>		13c. CITY OR TOWN <b>CHESTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>P.O. BOX 58A</b>	
14. FATHER'S NAME First Middle Last <b>IRVIN RICHARDSON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA LEE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>YES WW II</b>		16b. SOCIAL SECURITY NO <b>218 16 63 13</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHRONIC RENAL FAILURE DUE TO DIABETES MELLITUS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ANEMIA NORMOCYTIC NORMOCHRONIC SEC. TO #1</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? <b>NO AUTOPSY</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>9/9/68</b> , 19____, to <b>10/8/68</b> , 19____, that <b>he</b> (we) last saw the deceased alive on <b>10/8/68</b> , 19____, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>he</b> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Rodolfo G. Miro</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/9/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>RODOLFO G. MIRO, M. D.</b>				22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		23b. DATE <b>10/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHESTER CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>CHESTER, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>Barbara L. Dashiell</b>		ADDRESS <b>426 Dover St</b>		25a. REC'D BY REGISTRAR <b>DASHIELDS FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 11 1968</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR A:00 M	
HARVEY			M.ARC			RICHMAN		Oct. 8, 1968	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR A:00 M	
male	white	7-11-1968	YRS 3			October 8, 1968		7:00 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore, Md.		U.S.A.				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Pikesville			RANDALLSTOWN Balto. Co. Gen. Hosp.			NONE		NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Maryland			Baltimore			4707 Maryknoll Road			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
MYRON			RI CHMAN			CHARLENE KIRSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO			NO		MR. JEROME KIRSON. 8533 STEVENSWOOD RD. #7				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis (SDMI)</u>									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED
Werner U. Spitz, M.D.					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		10/8/68		
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL		10-9-68	HEBREW YOUNG MEN			BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					DATE OCT 9 1968		J. Charles Judge		



14120

CERTIFICATE OF DEATH

14129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LUTHERVILLE</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Same as 2.d. the ongoing line. 7th</u>		d. STREET ADDRESS <u>Route #1, Box 429, Lutherville P.O., Md.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA ELIZABETH RIGGER</u>		4. DATE OF DEATH Month Day Year <u>10 / 27 / 1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/24/1877</u>
9. AGE (In years last birthday) <u>91</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Duke</u>		14. MOTHER'S MAIDEN NAME <u>Cecilia O'Brien</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO <u>216-14-0390</u>	
17. INFORMANT <u>Mrs. Margaret A. Volland</u>		Address <u>Lutherville Md. Rt. 1, Box 429</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Atherosclerotic Cardiovascular Disease</u> (b) <u>Viremia</u> DUE TO <u>viral bronchitis</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____			INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u> <u>2 days</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myxedema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>14/18/1960</u> to <u>10/27/1968</u> ; that (I) (we) last saw the deceased alive on <u>10/26/1968</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gerald N. Maggid</u>		22b. DATE SIGNED <u>10/27/68</u>	22c. PHYSICIAN'S NAME (Type) <u>Gerald N. Maggid, M.D.</u>
22d. ADDRESS <u>Pikesville Medical Center - Balto., Md. 21209</u>		22e. REC'D BY REGISTRAR DATE <u>NOV 4 1968</u>	
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>Oct. 30, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore Md.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>		23e. ADDRESS <u>Frank H. Newell, Pikesville, Md.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1 DECEASED NAME (Type or print)			First Cyril			Middle George			Last Robinson			2a. DATE OF DEATH Month October			Day 6			Year 1968			2b. HOUR 9:15 P.M.		
3 SEX male			4 RACE Negro			5 DATE OF BIRTH February, 1902			6 AGE (In years lost birthday) 66 YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			IF UNDER 24 HRS. HOURS			M.N.		
7a BIRTHPLACE (State or foreign country) Florida			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County Md.														
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired Merchant Marine			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) - STATE Maryland			13b. COUNTY Baltimore City			13c. CITY OR TOWN Baltimore City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1916 West Mulberry Street											
14 FATHER'S NAME (dec'd.) Emanuel			First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last			Address														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 220-03-9351-A			17. INFORMANT Records: Spring Grove State Hospital			Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent CVA. (cerebrovascular accident)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus.</u> Conditions, if any, which gave rise to immediate cause (a), noting the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>250x</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No			City or Town			County			State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug. 7, 1968</u> , to <u>Oct. 6, 1968</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Oct. 6, 1968</u> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death																							
22b. SIGNATURE <u>Rafael H. Marin</u>			DEGREE			ATTENDING PHYS			<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 10-7-68											
22d. PHYSICIAN'S NAME (Type)			Rafael H. Marin, M.D.			22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 10/10/68			23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary			23d. LOCATION (City or Town) Brooklyn, Maryland			(County) (State)											
24. FUNERAL DIRECTOR Charles A. Rice			661 W. Barre St.			25a. REC'D BY REGISTRAR DATE OCT 8 1968			25b. REGISTRAR'S SIGNATURE <u>Charles A. Rice</u>														





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14122									
14131									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Lester L. Robinson						Month 10 Day 2 Year 1968			7 M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE	W		6-18-79			81 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
CATONSVILLE			SUMMIT						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER		
MD			HARWOOD PARK		YES		1110 Louden Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George L. Robinson			Mary C. CLUNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
			705-05-4051		Mr. Lester L. Robinson, Jr. 4524 Northwood Dr				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE RECTUM									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Retrospective cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
154x									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No.				
22a. I certify that (I) (this hospital) attended the deceased from SEPT 28, 1968, to OCT 2, 1968, that (I) (we) last saw the deceased alive on SEPT 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
S. KASATI'S, M.D.							10/2/68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
E. KASATI'S, M.D.			1801 FREDERICK RD, BALTO + 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			10-5-1968		Louden Park Cemetery		Baltimore, Maryland		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Howard H. Hubbard, 4107 Wilkens Ave. 21229							OCT 4 1968		Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11123

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14132

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Irene</b>			First Middle Last <b>Roe</b>			2a. DATE OF DEATH Month Day Year <b>10- 14 68</b>			2b. HOUR 10:30 AM		
3 SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>1-1-1892</b>			6. AGE (In years last birthday) <b>76</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Talbot Co., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6408 Walnut Street</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>School Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE <b>MD</b>			13b. CITY <b>Balto</b>			13c. CITY OR TOWN <b>Woodlawn</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>6408 Walnut Street 21207</b>			14. FATHER'S NAME First Middle Last <b>William E. Roe</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida William</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>215-40-4723A</b>			17. INFORMANT Address <b>Edith W. Mills-6408 Walnut Street 21207</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Nephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arterio Sclerosis</b>									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <b>6 yrs</b> <b>2 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>420c</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19 1942</b> to <b>Oct. 11 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct. 10 1968</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.											
22b. SIGNATURE <b>Earl L. Chambers</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/12/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers - M.D.</b>						22e. ADDRESS <b>100-W. Cold Spring Lane - Balto</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-14-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Easton, Maryland</b>		
24. FUNERAL DIRECTOR <b>Ellsworth Armacost - 4600 Liberty Hghts. Avenue</b>						25a. OCT 14 1968 DATE			25b. BY REGISTERED <b>John Judge</b>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14133	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST DEATH MATED		2b HOUR	
Vernon		T.		Ruggles		Jr.		October 13 1968		4:47 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR
male	white	9/15/22		46 YRS					October 13 1968		4:47 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore		USA		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Baltimore					
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Baltimore				St. Joseph Hospital							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d NO. OF CITY, W. 157		13e STREET AND NUMBER	
Md				Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4301 Kolb Ave., 21206	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
Vernon T. Ruggles Sr.				Elsie Ditzel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No Yes				1943-1946		Mrs. Elsie Hornig		806 S. Maderia Street			
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
						ADDRESS (Street, city, town, or county)		22b DATE SIGNED		10/13/68	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		10-17-1968		Moreland Memorial Park		Baltimore County, Maryland					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Lilly & Zeiler Inc. 1901-07 Eastern Ave.								OCT 14 1968		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 11/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Lillian Pauline Sachs</b>					2a. DATE OF DEATH <b>10</b> Month <b>12</b> Day <b>68</b> Year			2b. HOUR <b>5:45a</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>4-19-02</b>		6. AGE (In years last birthday) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson, Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balt. Med. Cent.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>21214 4624 Crosswood Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Vana</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. <b>216-12-0926 B</b>		17. INFORMANT Address <b>John F. Sachs, husband, above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>10x1</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Obstruction of main stem bronchus</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>160x</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>10-07</b> , 19 <b>68</b> , to <b>10-12</b> , 19 <b>68</b> , that (I) (we) saw the deceased alive on <b>10-12</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Meskinpour</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-12-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Hooshang Meshkinpour</b>					22e. ADDRESS <b>6701 Charles St.</b>				
23a. BURIAL, CREMATION, REMOVA. (Specify) <b>Burial</b>		23b. DATE <b>10/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11126

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14135

1. DECEASED NAME (Type or print) <b>Odilia</b>		First Middle Last <b>Sandner</b>		2a. DATE OF DEATH Month Day Year <b>October 28 1968</b>		2b. HOUR <b>6:10 P.M.</b>	
3 SEX <b>F.</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 15, 1878</b>		6. AGE (In years last birthday) <b>90</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Beth N. Home</b>		12a. USUAL OCCUPATION (Kind of work done during week before death, even if retired) <b>Needle Work</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Womens Exchange</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <b>1010 Walnut Ave. 21229</b>		14. FATHER'S NAME First Middle Last <b>John Sandner</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna Lucke</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>213-540645</b>		17. INFORMANT <b>S. H. Lucke (Cousin)</b>		Address <b>Randallstown 922-5725</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis - generalized</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 26, 1967</b> , to <b>October 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>October 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>McSwilliam</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct 28, 1968</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>11904 Reisterstown Rd Reisterstown Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 31, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. Randallstown, Md</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1  
11127  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
14136  
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
Theresa		M.		Schanken	October 28 1968		M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
F	W		4-25-1893		75 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Violetsville		3808 Coolidge Avenue		Housewife & Ret. Cook					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Violetsville				3808 Coolidge Avenue 21229	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Joseph H Carter		Mary Heidrich							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		216-03-9345A		Marie Haynie		21229			
				3808 Coolidge Ave.		Violetsville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>								5 mos	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
July 8 1968		Abdominal Tumor		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1965</u> to <u>Oct 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Earl I. Pass</u>				22c. DATE SIGNED		10-29-68			
22d. PHYSICIAN'S NAME (Type) Dr. Earl I. Pass				22e. ADDRESS		4001 Wilkens Avenue, Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11-1-68		Loudon Park Cemetery		Baltimore City, Baltimore Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard, 4107 Wilkens Ave. Balto				OCT 31 1968		Charles Judge			

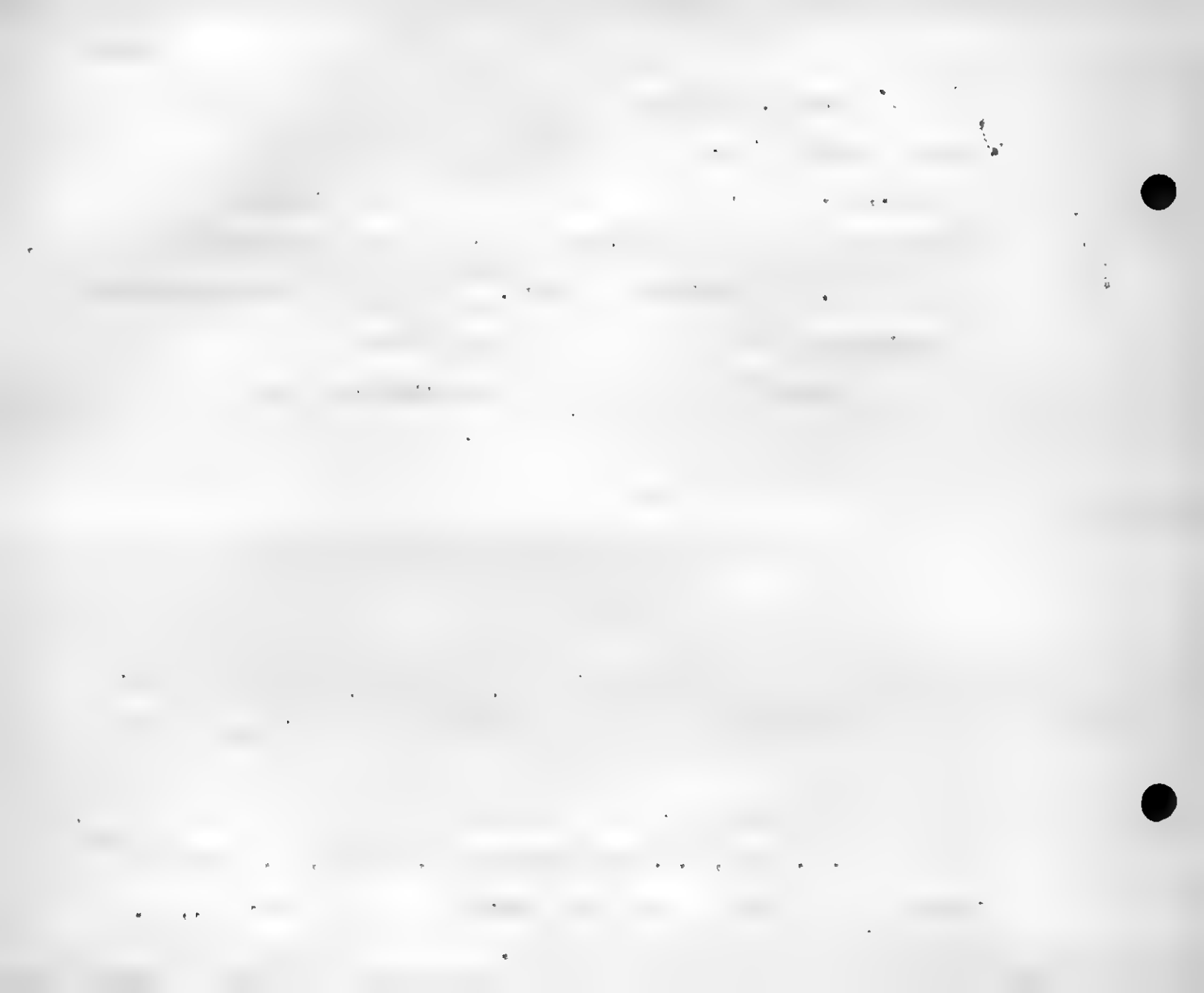


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14137	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <b>12128 CARL H. SCHNEIDER</b>			First Middle Last			2a. DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 10/16 1968			2b. HOUR <b>8:30</b> M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3/4/29</b>		6. AGE (in years last birthday) <b>39</b> YRS		7c. DATE PRONOUNCED DEAD <b>10/16</b> Day Year <b>1968</b>		2d. HOUR <b>11:30</b> M	
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARR.ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Essex (21221)</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Bay Avenue (Rural)</b>			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Computer Technician</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		
13a. USUAL RES. DENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. INS. DE CITY LIM. 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Charles Schneider</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Duerr</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO <b>20-20-284</b>		
17. INFORMANT <b>Janice Schneider</b>			ADDRESS <b>Same</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gun shot wound thru head</b> <b>955X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>976X</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>none</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>10/16 1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Shot by 31st Inf. Brn.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, etc.) <b>Bay Ave - (Road)</b>			21f. LOCATION Street R.F.D. No City or Town County State <b>Bay Ave - Balto Essex 21 - Balto Md</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>M B Davis</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10/18/68</b>		
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D. 6800 Mornington Rd. Dundalk, Md. 21222</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
23a. BURIAL, CREMATION, or other disposal <b>Burial</b>			23b. DATE <b>10/19/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co., Md.</b>		
24. FUNERAL DIRECTOR <b>Brzudzinski Funeral Home 1407 Eastern Ave.</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE <b>OCT 21 1968</b>											



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

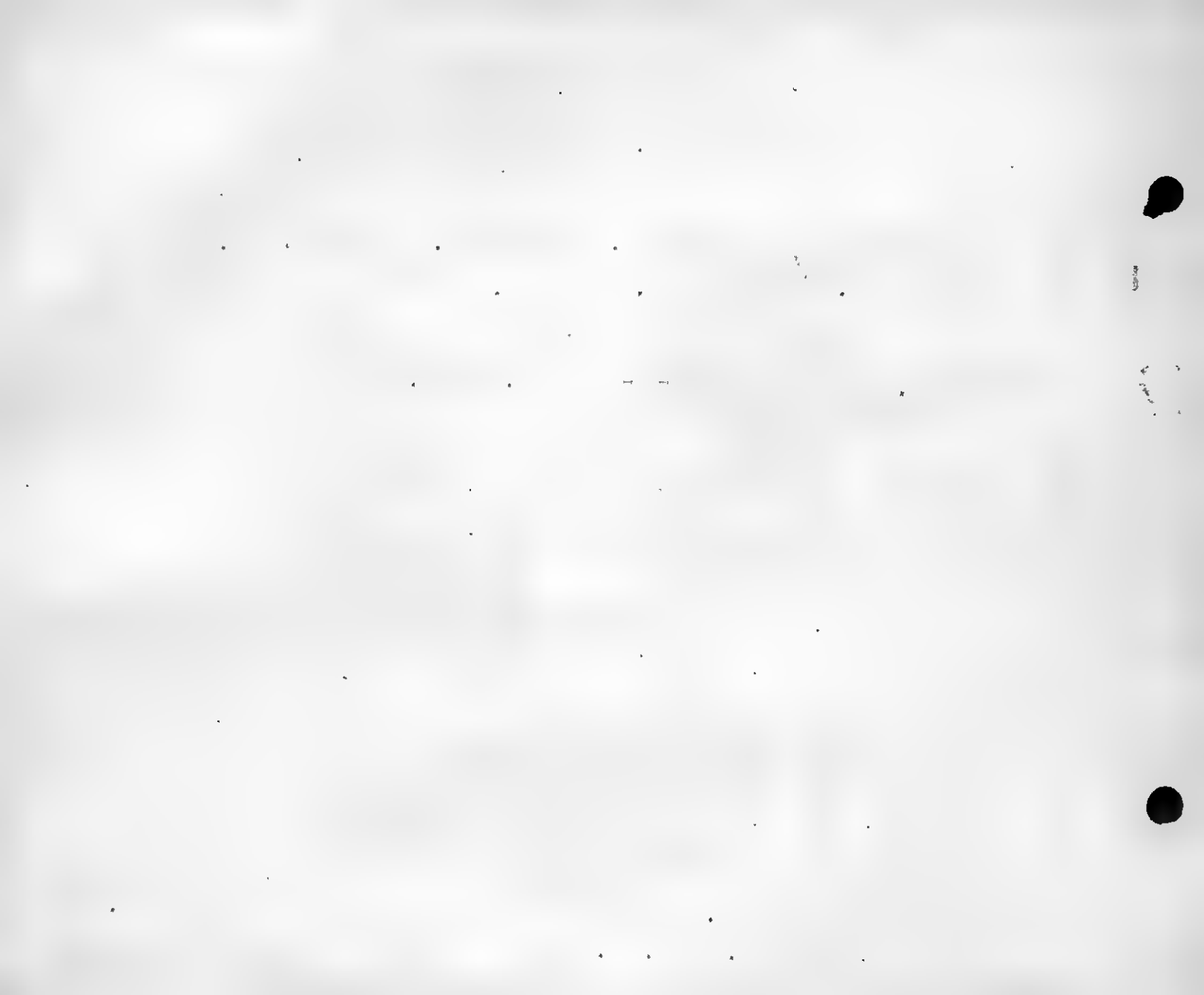
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14129

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14138

1 DECEASED-NAME (Type or Print)		First WILLIAM		Middle		Last SCHOEBERLEIN		2a DATE KNOWN OF EST. DEATH MATED		Month October		Day 7		Year 1968		2b HOUR 3:45 PM	
3. SEX Male		4 RACE White		5 DATE OF BIRTH June 10, 1894.		6 AGE (In years and birthday) 74 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month October		Day 7		Year 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore,											
10 CITY OR TOWN OF DEATH Towson				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) St. Joseph's Hosp.				12a. USLA. OCCUPATION (Kind of work done during most of working life, even if retired) Retired-- Balto. City Police				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3107 Moreland Avenue							
14 FATHER'S NAME First Conrad				Middle Schoeberlein		Last Elizabeth		15 MOTHER'S MAIDEN NAME First Elizabeth				Middle ?		Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.				(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-44-6975		17 INFORMANT Mrs. Anna K. Schoeberlein				ADDRESS (Same)					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus																Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b) Fractured Left Hip																7 Days	
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic C-R-V																1 day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION None								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH Falls								21b. TIME OF INJURY Month, Day, Year 9/30 1968 P.M.								21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Family Business Fell down Several Steps	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>								21e. PLACE OF INJURY (At home, farm, street, factory office building, etc) Home								21f. LOCATION Street or RFD No 3107 Moreland Ave City or Town Baltimore County City and State Md	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.								CHIEF MEDICAL EXAMINER <input type="checkbox"/>								22b. DATE SIGNED 10/12/68	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
								ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVA (Specify) Burial				23b. DATE 10/10/68.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City or Town) Baltimore, Md.				(County) (State)			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214								ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 8 1968				25b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1-68

14130

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14139

# CERTIFICATE OF DEATH

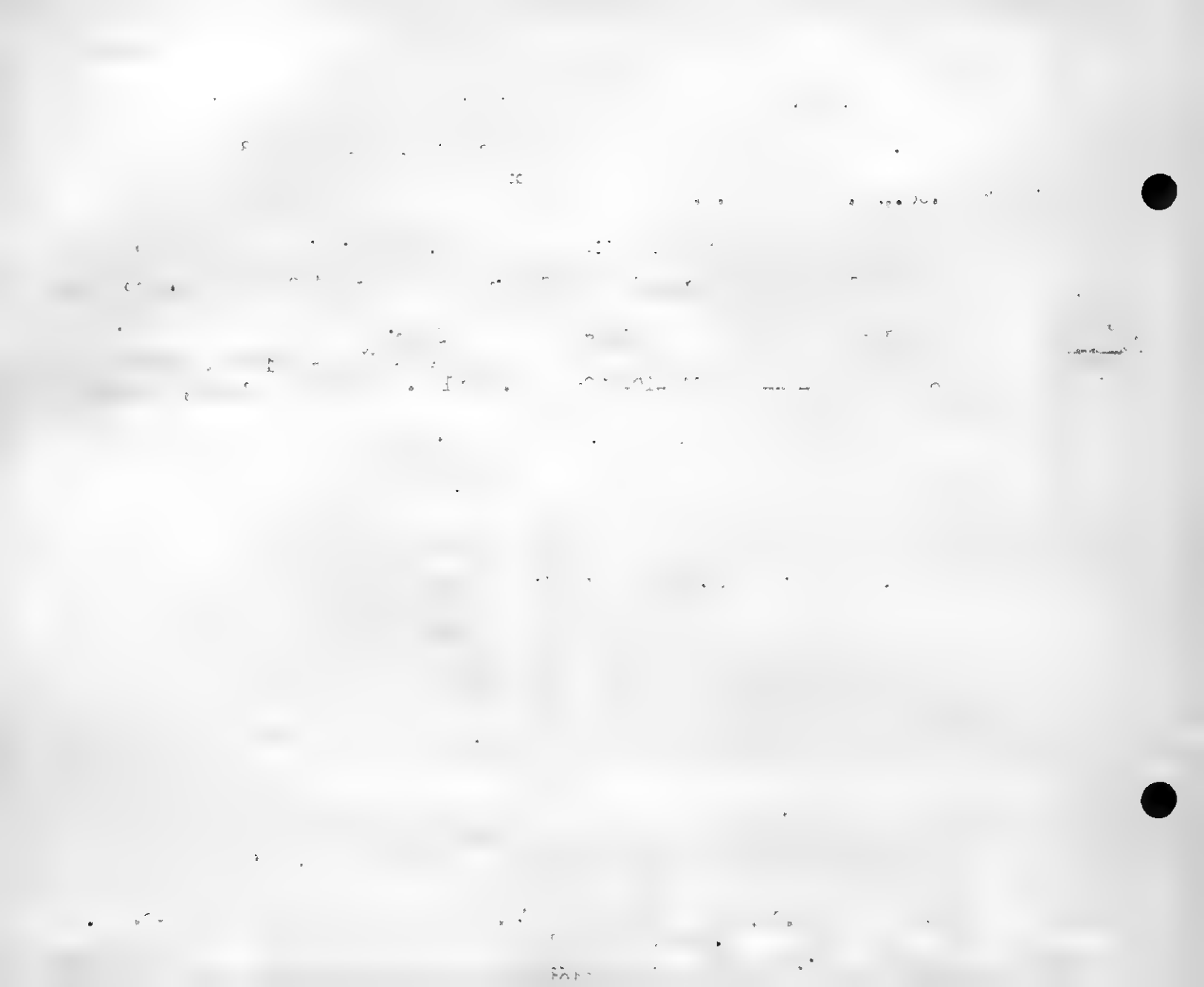
1. DECEASED-NAME (Type or print) <b>Alfred W. SCHROBSDORFF</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>4 A. M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11-19-1901</b>		6. AGE (In years last birthday) <b>66</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tool Maker--Western Electric</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>7913 Oakdale Ave.</b>							
14. FATHER'S NAME First Middle Last <b>August Schrobsdorff</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Auguste Gunther</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>218-03-0832A</b>		17. INFORMANT Address <b>Mrs. Ella Schrobsdorff (Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>1510</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of head of pancreas with extensive metastasis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1511</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <b>Dr. (this hospital)</b> attended the deceased from <b>10/15/</b> , 19 <b>68</b> , to <b>10/30/</b> , 19 <b>68</b> , that <b>Dr. (we)</b> last saw the deceased alive on <b>10/30/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Christina Feliciano, M.D.</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/30/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Christina Feliciano, M.D.</b>				22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/2/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Helen			Middle Lee			Last Schurman			2a. DATE OF DEATH 10 Month 24 Day 68 Year			2b. HOUR 12:05 PM		
3 SEX Female			4. RACE Cau.			5. DATE OF BIRTH October 21, 1915			6. AGE (In years last birthday) 53 YRS.			7. UNDER 1 YEAR MONTHS DAYS HOURS M N			8. UNDER 24 HRS. MONTHS DAYS HOURS M N		
7a. BIRTHPLACE (State or foreign country) Balto. Co., Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker								
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 102 South Lynbrook Road					
14. FATHER'S NAME First Middle Last Alvin Sipes			15. MOTHER'S MAIDEN NAME First Middle Last Blanche Lee														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or (unknown) No			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 212-10-9439			17. INFORMANT (Husband) 838-5544 Mr. Paul F. Schurman			102 S. Lynbrook Road Bel Air, Maryland 21014								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Widespread carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1010</u> (b) <u>Carcinoma of right kidney</u> DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Gastrointestinal hemorrhage from duodenal ulceration</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> , 19 <u>68</u> , to <u>10/24</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>10/24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Rudiger Breitenecker</i>			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/24/68								
22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.			22e. ADDRESS 6701 N. Charles Street														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Oct. 26, 1968			23c. NAME OF CEMETERY OR CREMATORY Fairview Meth. Ch. Cem.			23d. LOCATION (City or Town) (County) (State) Sunnybrook, Balto. Co., Md.								
24. FUNERAL DIRECTOR <i>Foster Funeral Home</i>			ADDRESS W. Broadway & Williams			DATE OCT 28 1968			REGISTERED SIGNATURE <i>Charles Judge</i>								



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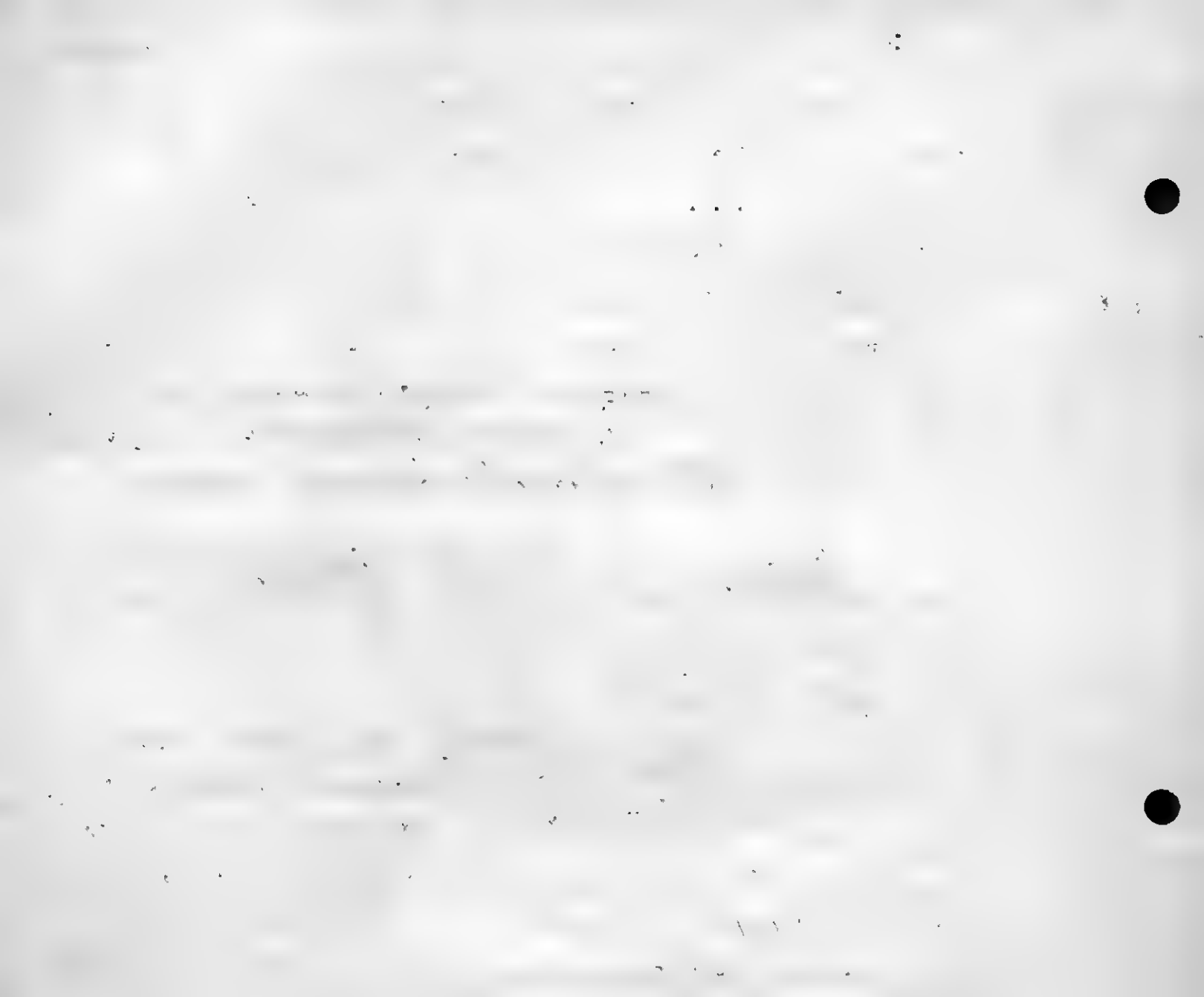
14132

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14141

1. DECEASED NAME (Type or print) First Middle Last <b>Helen Ograta Seebacher</b>			2a. DATE OF DEATH Month Day Year <b>10 22 68</b>			2b. HOUR <b>1:30A</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 1, 1901</b>		6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md			
10. CITY OR TOWN OF DEATH <b>Carney</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2903 Erie Ave</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Carney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2903 Erie Ave</b>	
14. FATHER'S NAME First Middle Last <b>Harry Timmons</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Minnie Unverzagt</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <b>213-12-4138A</b>		17. INFORMANT <b>Mr William H Seebacher</b>			Address <b>Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4107 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Cardiovascular Disease</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sudden</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Stroke 4-5 yr. previous</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 1966</b> , to <b>Oct 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 1968</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. <b>Examined Pronounced Dr J C Hyle</b>									
22b. SIGNATURE <b>Frank T Kasik Jr</b>		22c. DATE SIGNED <b>10/22/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Frank T Kasik Jr M D</b>		22e. ADDRESS <b>9005 Harford Rd Baltimore, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc Baltimore, Maryland</b>				25a. REC'D BY REGISTRAR <b>OCT 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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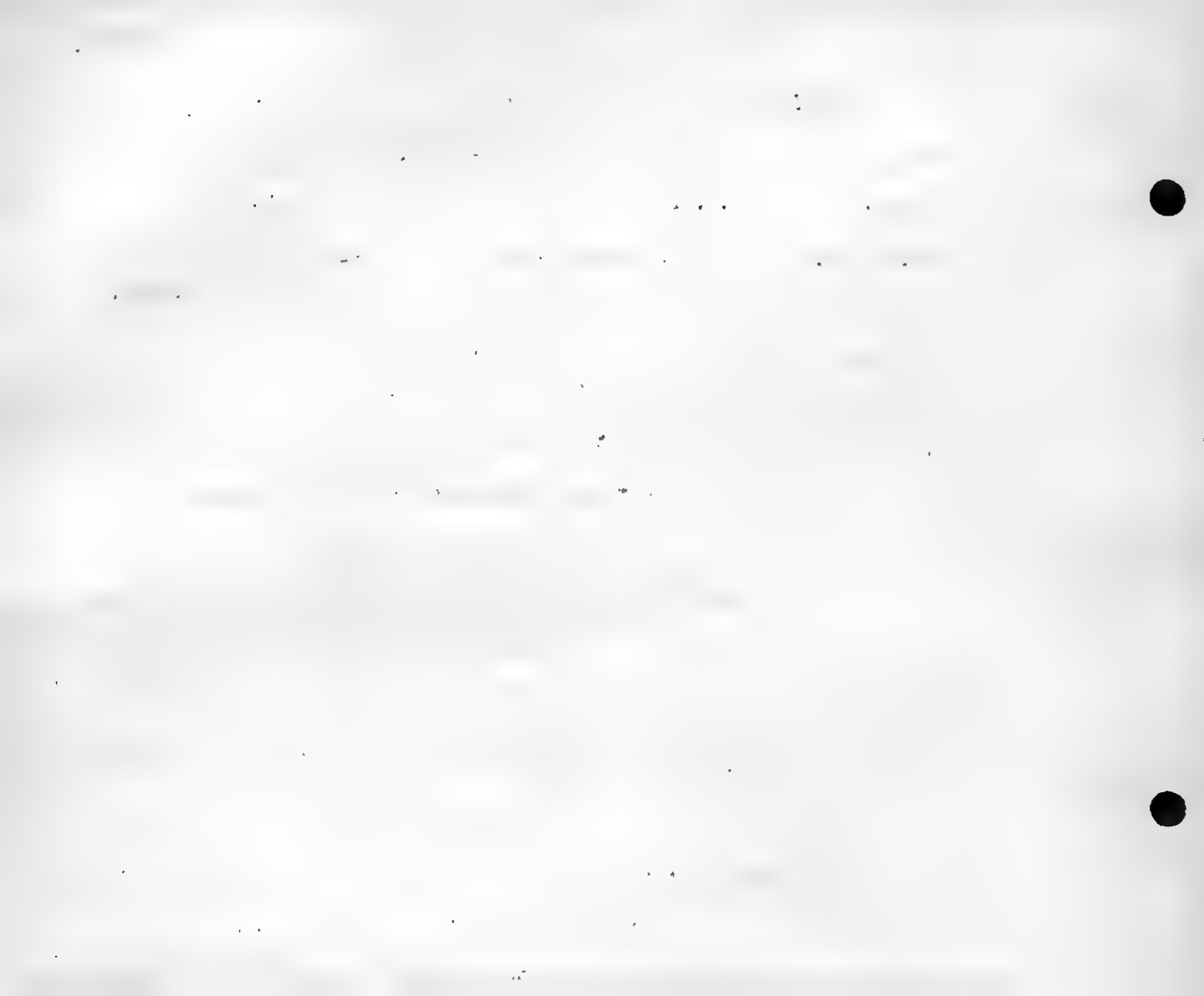
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14133

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14142

1. DECEASED NAME (Type or print) <b>Hattie B Shotts</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>1</b> Year <b>68</b>			2b. HOUR <b>5:15P M</b>					
3 SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>8-9-1890</b>		6. AGE (in years last birthday) <b>78 YRS.</b>		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8407 Harris Ave.</b>			
14. FATHER'S NAME First <b>JESSE V.</b> Middle <b>SHOTTS</b>			15. MOTHER'S MAIDEN NAME First <b>Augusta V</b> Middle <b>Shawley</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <b>199-24-9188</b>		17. INFORMANT Address <b>Family records</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4.1</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>10</b> Day <b>1</b> Year <b>68</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>9-26-68</b> , 19 <b>68</b> , to <b>10-1</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-1</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Beatriz Dizon</b>				DEGREE <b></b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-1-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Beatriz Dizon, M.D.</b>				22e. ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City or Town) <b>Baltimore</b>		(County) <b>Md.</b>		(State) <b></b>	
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>				ADDRESS <b></b>		25a. REC'D BY REGISTRAR <b>OCT 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

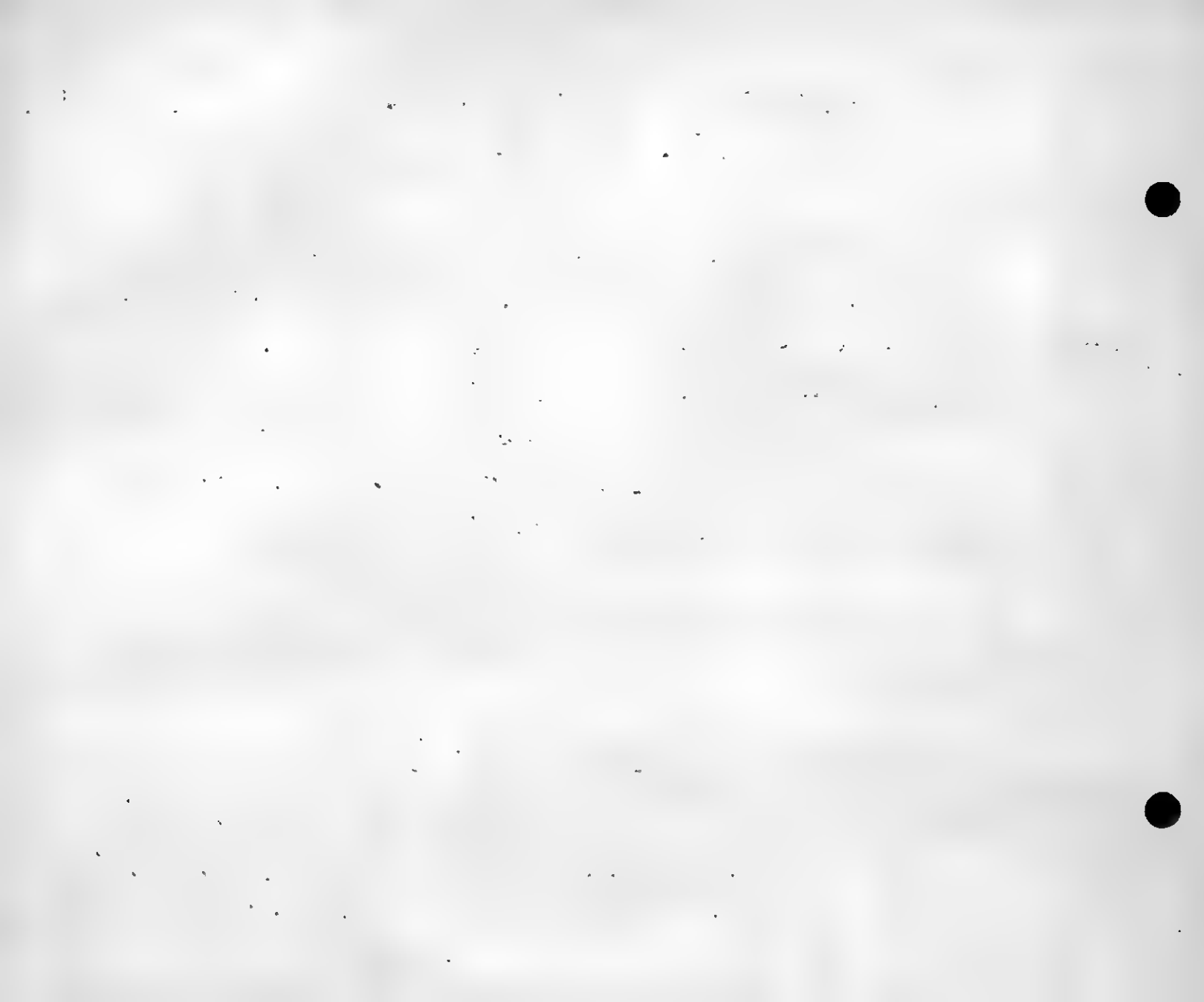




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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>JENNIE SILVERMAN</b>						2a. DATE OF DEATH Month <b>10</b> Day <b>25</b> Year <b>68</b>					
3. SEX <b>Female</b>		4. RACE <b>White Hebrew</b>		5. DATE OF BIRTH <b>3-17-69</b>		6. AGE (In years last birthday) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Russia</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Catonsville Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Spring Grove State Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>domestic</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>120 S. Exeter St.</b>			
14. FATHER'S NAME First <b>Marcus</b> Middle <b>Silverman</b> Last <b>Silverman</b>				15. MOTHER'S MAIDEN NAME First <b>Bessie</b> Middle <b>Goldman</b> Last <b>Goldman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-54-3416</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure due</b> <b>4122</b> DUE TO, OR AS A CONSEQUENCE OF <b>arteriosclerotic cardio-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>insular disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>insular disease.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 25, 19 29</b> to <b>Oct. 25, 19 68</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Rafael H. Marin</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/25/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Rafael H. Marin, M.D.</b>				22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>		23d. LOCATION (City or Town) <b>Balto</b>		(County) <b>Md</b>		(State)	
24. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, Inc</b>				ADDRESS <b>9610 Reisterstown Rd</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15  
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14133									
14144									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b HOUR
James Smiley Smith						Month 10 Day 21 Year 68			06:19
3. SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR
Male		White		12/30/1887			80 YRS		IF UNDER 24 HRS
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Penna		U.S.A.					Baltimore		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Baltimore			5201 Old Frederick Rd.			Railroad retiree			Railroad
13a U.S.A. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.			Balto.		Balto.		YES		5201 Old Frederick Rd. 21229
14 FATHER'S NAME			15. MOTHER'S M.A.D.E.N NAME						
First Middle Last			First Middle Last						
Frederick G. Smith			Martha Smiley						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
No			705-09-1552		Mrs. James S. Smith, 5201 Old Frederick rd.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Undetermined</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Senility</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (we) attended the deceased from <u>10-21</u> , 19 <u>68</u> , to <u>10-21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>A. Bradley Daugharty, M.D.</u>					22c. DATE SIGNED 10-22-68				
22d PHYSICIAN'S NAME (Type) Dr. Daugharty					22e ADDRESS 1264 Francise Avenue, 21227				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial		10/24/68		Lorraine Mausoleum			Woodlawn, Maryland		
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229					25a. BY <u>John S. Judge</u>		25b. JUDGE		
					DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

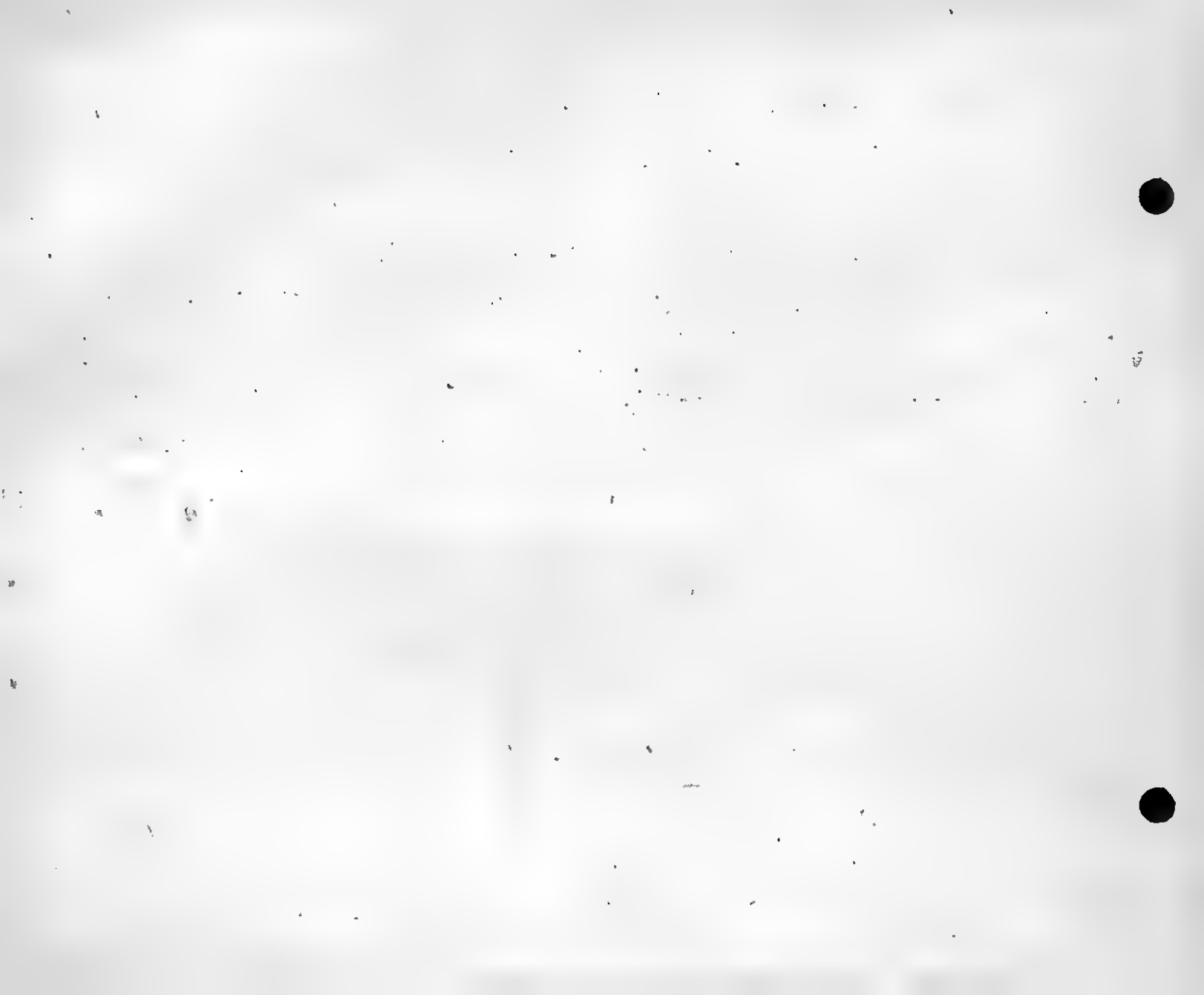
14136

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14145

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>JOHN WILLIAM HAROLD SMITH</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>19</b> Year <b>68</b>			2b. HOUR M	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Feb. 22, 1896</b>		6. AGE (In years last birthday) <b>72</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto</b>	
10. CITY OR TOWN OF DEATH <b>PIKESVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>204 MCHENERY AVE. Pikesville</b>		12a. USUA: OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>BALTIMORE CO.</b>		12b. KIND OF BUSINESS OR IND. STRY <b>Rds. Div.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>PIKESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>304 MCHENERY AVE.</b>		14. FATHER'S NAME First <b>JOHN</b> Middle <b>ROBERT</b> Last <b>SMITH</b>		15. MOTHER'S MAIDEN NAME First <b>CARRIE</b> Middle <b>H.</b> Last <b>BATES</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>W. W. F.</b>		17. INFORMANT <b>MRS ETTIE BENKE SMITH, 304 McHenry Ave.</b>		Address <b>Pikesville 8, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4104</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 10, 1967</b> to <b>Sept 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>9/28</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Edwin L. Pierpont, M.D.</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/19/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>				22e. ADDRESS <b>8204 LIBERTY RD. - BALTO, 21207 MD.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <b>Oct. 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Daniel Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville Balto Md.</b>	
24. FUNERAL DIRECTOR <b>Frank H. Newell</b>		ADDRESS <b>Pikesville 8, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1113

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14146

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>EDWARD LEE STALLINGS</b>			2a. DATE OF DEATH <b>Oct. Month 4, Day 1968.</b>		2b. HOUR <b>3:00 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 3, 1896.</b>		6. AGE (In years lost birthday) <b>72 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Parkville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>9648 Alda Ave. Dr.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Guard</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Oil Co.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>9648 Alda Drive</b>	
14. FATHER'S NAME First Middle Last <b>John Stallings</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna Beyer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO. <b>214-01-4560</b>	17. INFORMANT Address <b>Mrs. Isabelle Heisterman (Same)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebrovascular occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerotic Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Previous Cerebro Vascular occlusion 7 yrs ago.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one hour.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Previous Cerebro Vascular occlusion 7 yrs ago.</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1961</b> to <b>Oct 1968</b> , that (I) (we) last saw the deceased alive on <b>July 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>F.T. KASIK JR.</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>10/4/68.</b>		
22d. PHYSICIAN'S NAME (Type) <b>F.T. KASIK JR.</b>		22e. ADDRESS <b>9005 HARBOR RD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/7/68.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1968</b>	25b. DECEASED'S SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14133											
14147											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <b>Emma O'Tillie Staylor</b>						2a. DATE OF DEATH Month <b>Oct.</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR AM <b>2:30</b> M		
3 SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Oct. 21, 1891</b>		6 AGE (in years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			Md.		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>120 Overbrook Rd.</b>				12a USUAL OCCUPATION (Kind of work done during most of work as life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>120 Overbrook Rd.</b>			
14 FATHER'S NAME First Middle Last <b>Henry Conrad</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Nobbe</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>212-07-8561 B</b>		17 INFORMANT <b>Mr. Ernest Staylor</b>				Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dr. Maria</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Guardrail Art. roadblock C. Road</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>January 1952</b> to <b>Oct 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles E. Carr, M.D.</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/28/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Charles E. Carr, M.D.</b>				22e. ADDRESS <b>3900 N. Charles St.</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/30/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

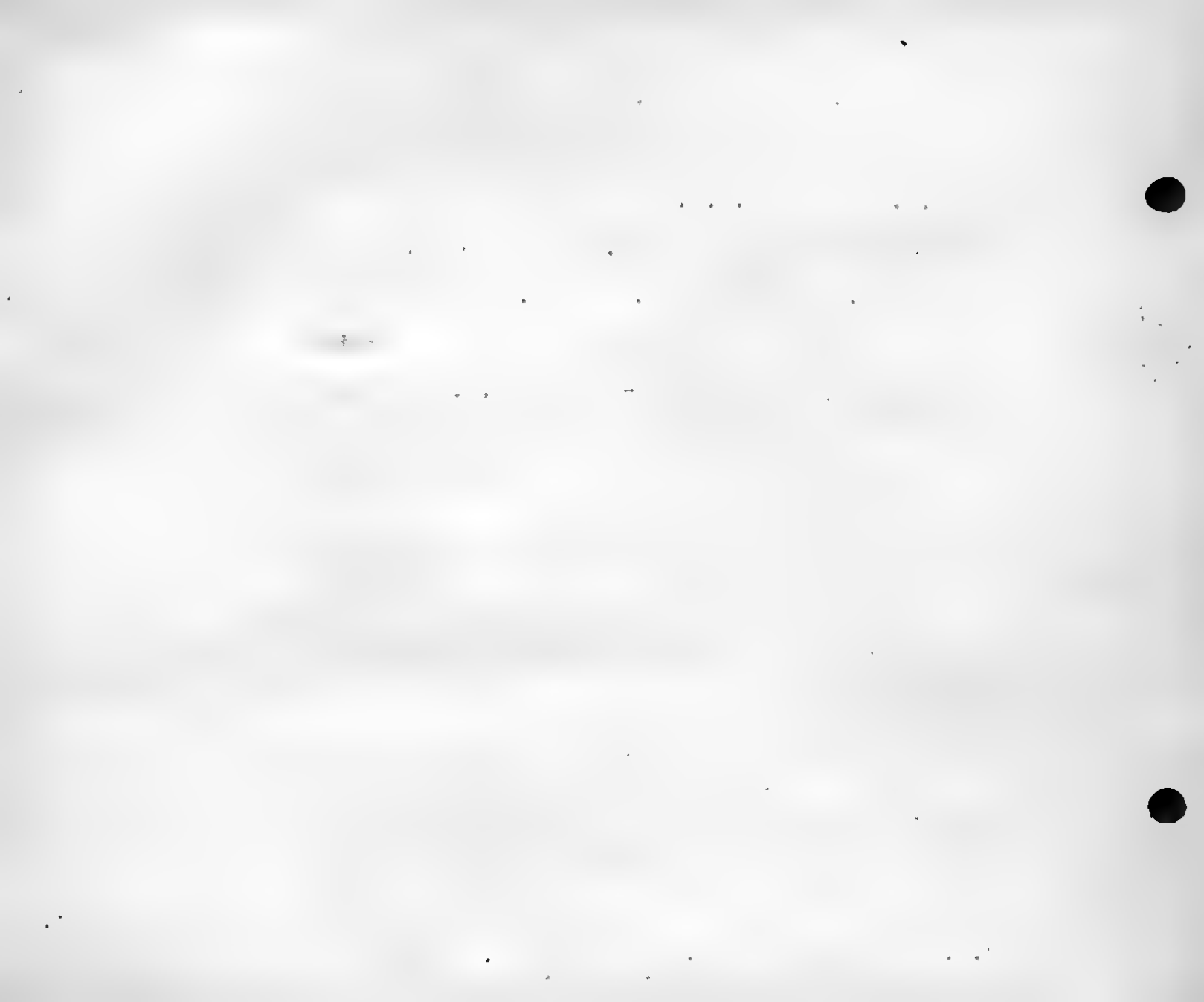


**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14148					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR				
George T. Steele									October 22 1968		10 PM				
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR			
M	W	7/24/1902		66 YRS		MONTHS DAYS		HOURS MIN		October 22 1968		8 PM			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
N.Y.			U.S.A.						Baltimore Md						
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Towson 21204				St. Joseph's Hosp.				Retired-Proprietor Food							
13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.				Balto.		Balto. 34		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9101 Covered Bridge Rd.					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last			
Thomas Steele									Edith Heorrell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS					
Yes				W.W.I.I.		212-09-3474A				Mrs. M. Annabelle Steele (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>												Sudden			
4109 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
42															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town		County State	
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				22b. DATE SIGNED							
<u>Charles F. O'Donnell</u>				Charles F. O'Donnell, M.D.				OCT 23 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)	
Burial				10/26/68		Crumpton				Church Hill				Md.	
24. FUNERAL DIRECTOR								ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H.W. Jenkins & Sons Co.								4905 York Rd. Balto. 12 Md.		DATE OCT 23 1968		<u>John J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14140

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14149

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First: <b>Nora</b> Middle: <b>A</b> Last: <b>Style</b>			2a. DATE OF DEATH 10 Month 21 Day 68 Year		2b. HOUR 3:35 PM
3. SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH <b>Feb 10, 1885</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (In years last birthday) 83 YRS.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>		9. COUNTY OF DEATH <b>Baltimore</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		12c. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	
14. FATHER'S NAME First: <b>John</b> Middle: <b>J</b> Last: <b>Sullivan</b>		15. MOTHER'S MAIDEN NAME First: <b>Margaret</b> Middle: <b>J</b> Last: <b>?</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO <b>213-09-72268</b>		17. INFORMANT Address: <b>Mr William N Style Style Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic cardiovascular disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>October 10, 1968</b> , to <b>October 21, 1968</b> , that (I) (we) last saw the deceased alive on <b>October 21, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Rudiger Breitenecker</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/22/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		22e. ADDRESS <b>6701 N. Charles Street</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		23e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <b>L. J. Buck Inc. Baltimore, Maryland</b>		24a. ADDRESS <b>3305 Bayview Rd</b>		24b. DATE <b>OCT 23 1968</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1574  
30M REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Mary</b>			First <b>E.</b> Middle <b>Sullivan</b> Last			2a. DATE OF DEATH <b>10</b> Month <b>19</b> Day <b>68</b> Year		2b. HOUR <b>12:10</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11-19-92</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Handalstown, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. Co. Gen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Reisterstown</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>406 S. cred heart rd.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Unknown</b> Last <b>Caney</b>			15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Martha</b> Last <b>Simons</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (specify) <b>no</b>		16b. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Mr. Emory Sullivan</b>		Address <b>Heart Lake, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 27, 1968</b> , to <b>OCT 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>OCT. 19, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Fausto Q. Aquino Jr.</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/19/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>FAUSTO Q. AQUINO JR.</b>				22e. ADDRESS <b>BALTIMORE COUNTY GEN. HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>OCT. 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>Frank H. Newell, Pikesville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 21 1968</b>			

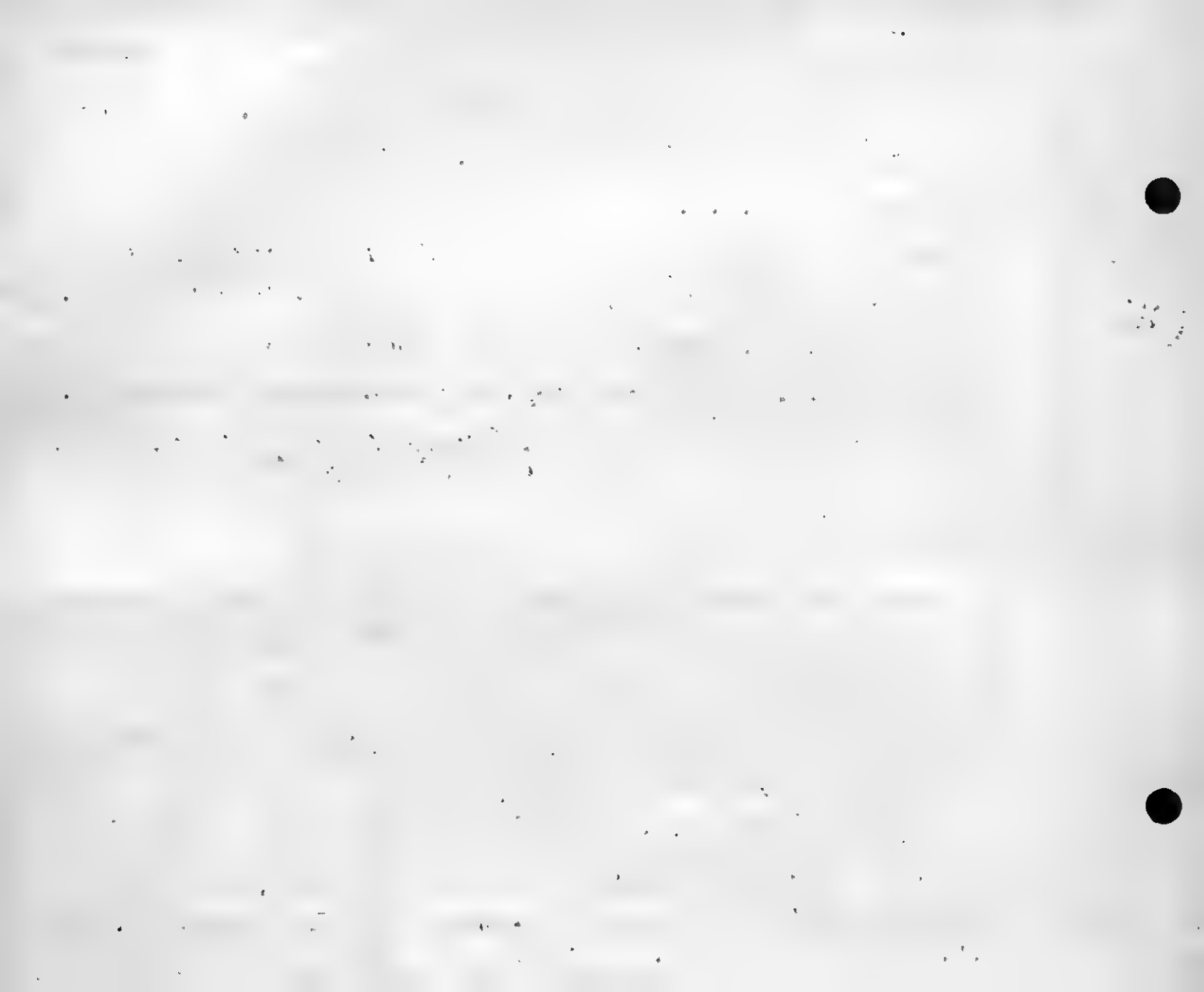




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 11 Film 406 11/2/68										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15142										14151									
1. DECEASED NAME (Type or print) <b>J MURRAY SWEENEY</b>					2a. DATE OF DEATH Month <b>OCT.</b> Day <b>30</b> Year <b>1968</b>					2b. HOUR <b>M</b>									
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>AUG. 30, 1894</b>			6. AGE (In years last birthday) <b>74</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>										
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6811 Bellona Ave. 21212</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED-PRESIDENT VASTER LOAN</b>			12b. KIND OF BUSINESS OR INDUSTRY										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>TOWSON</b>			13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>6811 BELLONA AVE.</b>							
14. FATHER'S NAME First <b>THOMAS</b> Middle <b>E.</b> Last <b>SWEENEY</b>					15. MOTHER'S MAIDEN NAME First <b>AGNES</b> Middle <b>MURRAY</b> Last														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>					16b. SOCIAL SECURITY NO. <b>W.W. 1 216-05-4540</b>					17. INFORMANT Address <b>MRS. JOSEPH L. MUTH 207 HOLLEN RD.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>with Chronic Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7/2/68</b>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (the hospital) attended the deceased from <b>April</b> , 19 <b>60</b> , to <b>OCT.</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/2/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>Wm. H. Kammer Jr. M.D.</b>										22c. DATE SIGNED <b>10/31/68</b>			22d. PHYSICIAN'S NAME (Type) <b>WM. H. KAMMER JR.</b>		22e. ADDRESS <b>6011 York Rd. 21212</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>11/2/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>			23e. REC'D BY REGISTRAR DATE <b>NOV 4 1968</b>			23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
24. FUNERAL DIRECTOR <b>H.W. NEARS &amp; SON 805 N. CALVERT ST</b>																			



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print) <b>Andrew</b>		First <b>G.</b>		Middle <b>Swingler</b>		Last <b>Swingler</b>		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Oct.</b> Day <b>21</b> Year <b>1968</b>		2b HOUR <b>M</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>Oct. 3, 1896</b>	6 AGE (In years last birthday) <b>72</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>		2c DATE PRONOUNCED DEAD Month <b>October</b> Day <b>21</b> Year <b>1968</b>		2d HOUR <b>M</b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b>					
10 CITY OR TOWN OF DEATH <b>Dundalk</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>9 Oakwood Road</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Machine Shop</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Patapsco R.R.</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Dundalk</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>9 Oakwood Road</b>			
14 FATHER'S NAME First <b>Louis</b> Middle <b></b> Last <b>Swingler</b>				15 MOTHER'S MAIDEN NAME First <b>Katherine</b> Middle <b></b> Last <b>Kelley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give year or dates of service) <b>WWI</b>		16b SOCIAL SECURITY NO <b>213-09-3537</b>		17. INFORMANT (Wife) <b>Mrs. Margaret Swingler, 9 Oakwood Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>HCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>420</b>											
19a. DATE OF OPERATION <b></b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>		21b. TIME OF INJURY Month, Day, Year <b></b> HOUR A.M. <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b></b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>		21f. LOCATION Street or R.F.D. No <b></b>		City or Town <b></b>		County <b></b>		State <b></b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Theodore C. Patterson</b>		EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b>		M.D. <b></b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 3724 Dundalk Ave.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b DATE SIGNED <b>Oct. 22, 1968</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>Dundalk, Md. 21222</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) <b>Baltimore, Maryland</b> (County) <b></b> (State) <b></b>					
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>						25a. REC'D BY REGISTRAR <b>OCT 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR 1-1-68  
304 REV. 1-68

13145

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14153

1. DECEASED NAME (Type or print) First Middle Last <b>Anthony N. Tallarico Tallarico</b>			2a. DATE OF DEATH Month Day Year <b>October 6, 1968</b>			2b. HOUR p. M. <b>1:30 p.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Sept. 1, 1906.</b>		6. AGE (In years last birthday) <b>62</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b> Md.</b>		13b. COUNTY <b> Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
13e. STREET AND NUMBER <b>2035 North Lakewood Ave.</b>							
14. FATHER'S NAME First Middle Last <b>Salvatore Tallarico Tallarico</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Vincenza Anania</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolism, bilateral</b> <b>450X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>April 14, 1932</b> , to <b>Oct. 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct. 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Anthony J. Young, M.D.</b>		22c. DATE SIGNED <b>10-7-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>			
22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/10/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Robert Lee Taylor Jr.			2a. DATE OF DEATH Month Day Year October 19 1968			2b. HOUR 5.30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-26-02		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales		12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 22 East Seminary Ave.		14. FATHER'S NAME First Middle Last Robert Lee Taylor, Sr.		15. MOTHER'S MAIDEN NAME First Middle Last Frances E. Mitchell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address Frances Duke Taylor, Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Carcinomatosis, primary left lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>10/4/1968</u> to <u>10/19/1968</u> , that <del>it</del> (we) lost the deceased alive on <u>10/19/1968</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) <del>not</del> view the body after death.							
22b. SIGNATURE <i>Christina Feleciano, M.D.</i>				22c. DATE SIGNED 10-19-68			
22d. PHYSICIAN'S NAME (Type) Christina Feleciano, M.D.				22e. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMAT., REMOVAL (Specify) Burial		23b. DATE Oct. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204				25a. REC'D BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>William M. TAYLOR</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1968</b>		2b. HOUR A <b>7:45</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>June 23-1902</b>		6. AGE (In years last birthday) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Butcher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Butcher</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>541 Benninghaus Rd. #21212</b>	
14. FATHER'S NAME First <b>Charles R.</b> Middle <b>Taylor</b> Last <b>Taylor</b>			15. MOTHER'S MAIDEN NAME First <b>Alice</b> Middle <b>Bristow</b> Last <b>Bristow</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>Mar 11</b>		16b. SOCIAL SECURITY NO. <b>217-05-0097</b>	17. INFORMANT <b>Wife: Bertha B. Taylor</b> Address <b>same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive myocardial infarction</b> <b>4100</b> DUE TO, <del>myocardial infarction</del> <b>coronary thrombosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>10-3-</b> , 19 <b>68</b> , to <b>10-11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-11</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Scillian</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>October 11, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>		22e. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 15 &amp; 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Grove Baptist Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Urbana, Va.</b>	
24. FUNERAL DIRECTOR <b>Eugenia K. Seitz</b>		ADDRESS <b>5209 York Road Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>	
Seitz Funeral Home Baltimore, Md. 21212		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## CERTIFICATE OF DEATH

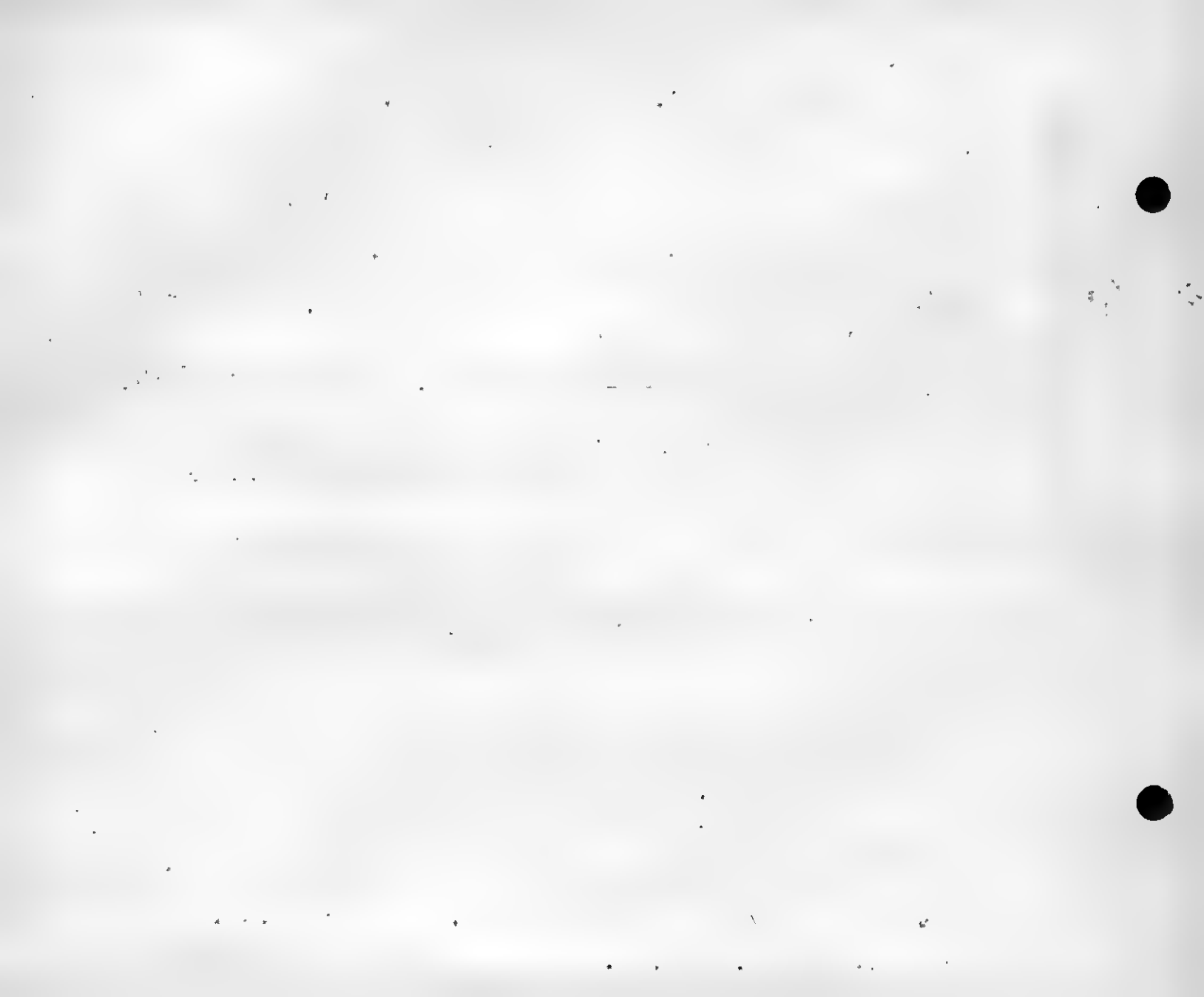
14156

16147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
John		A.		THIEL Sr.	Month 10 Day 8 Year 1968		12: P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 13, 1882		6. AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ret. Wholesale Produce		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before decease) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1243 Halstead Rd.
14. FATHER'S NAME Hall		15. MOTHER'S MAIDEN NAME Camille		16. SOCIAL SECURITY NO. 212-03-8907		17. INFORMANT Charles F. Thiel 10318 Malcolm Circle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> (If yrs give war or dates of service)		16b. SOCIAL SECURITY NO. 212-03-8907		17. INFORMANT Charles F. Thiel 10318 Malcolm Circle		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Old and acute and probable myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>secondary to severe coronary arterio-</u> Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		
19a. DATE OF OPERATION 9/16/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary obstruction		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21c. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I (this hospital) attended the deceased from 8/25/1968, to 10/8/1968, that I (we) last saw the deceased alive on 10/8/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.								
22b. SIGNATURE James E. M.D.		22c. DATE SIGNED 10-8-68		22d. PHYSICIAN'S NAME (Type) 6720 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/12/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Balto. Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25. REC'D BY REGISTRAR DATE OCT 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

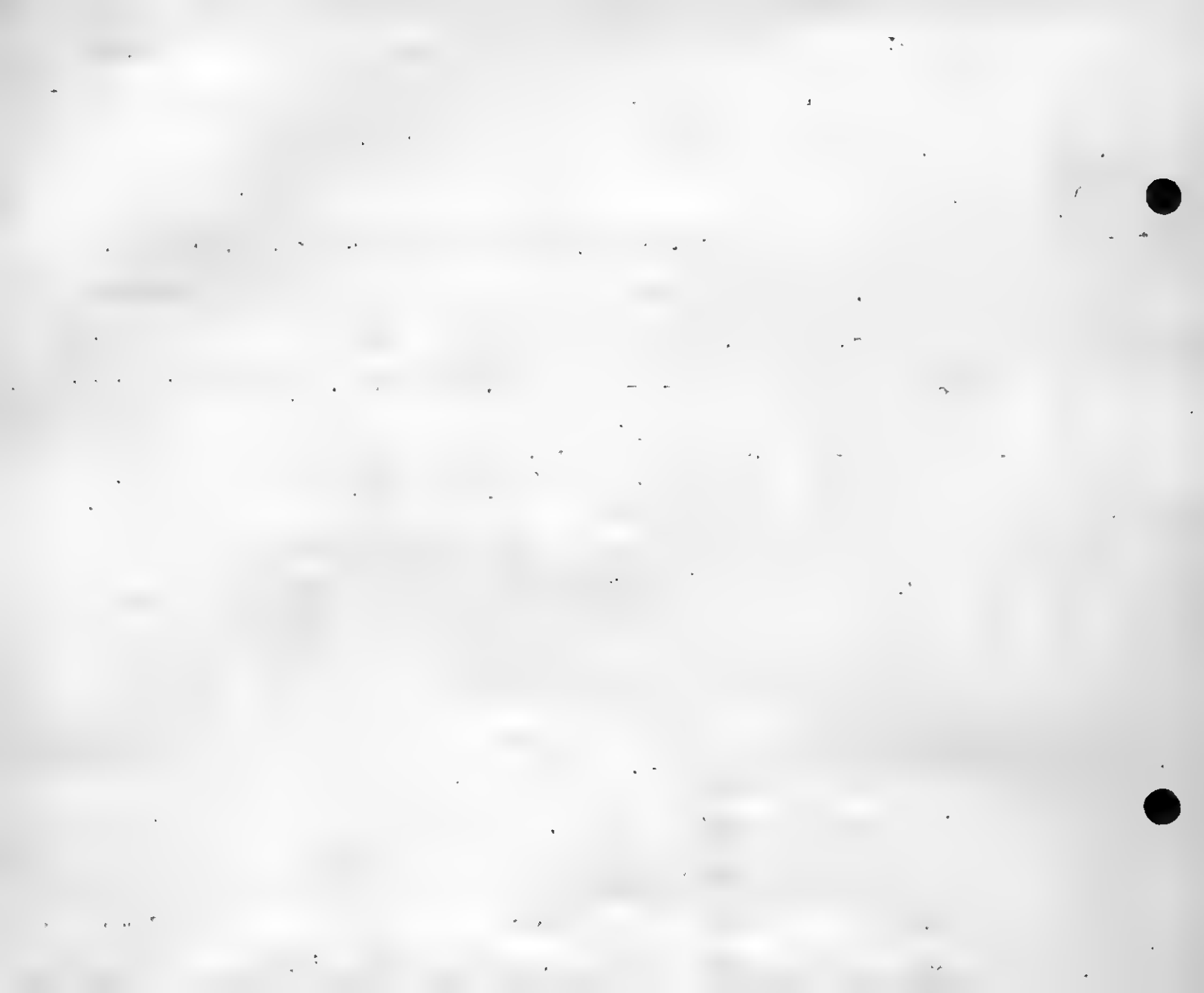
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14148

CERTIFICATE OF DEATH

14157

1. DECEASED-NAME (Type or print) <b>Bernard</b>		First <b>H.</b>	Middle	Last <b>Thompson Sr.</b>	2a. DATE OF DEATH Month <b>October</b> Day <b>28</b> , Year <b>1968</b>		2b. HOUR <b>5:15</b> AM		
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>June 24, 1908</b>		6. AGE (In years last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8204 Thornton Road 21204</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Vice Pres. Mt. Vernon Mills</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8204 Thornton Road</b>
14. FATHER'S NAME <b>Joseph B. Thompson</b>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Anna Miller</b>		First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-09-0061</b>		17. INFORMANT <b>Mrs. Elizabeth R. Thompson</b>			Address <b>8204 Thornton Rd.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF <b>arteriosclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>10 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>420 Cerebral Thrombosis (one yr ago)</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (1) (this hospital) attended the deceased from <b>Nov 5, 1967</b> , to <b>Oct 28, 1968</b> , that (1) (we) last saw the deceased alive on <b>Oct 21, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Walter R. Welzant, M.D.</b>				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Oct 29, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Walter R. Welzant</b>				22e. ADDRESS <b>Medical Arts Bldg.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 York Rd. #21212</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

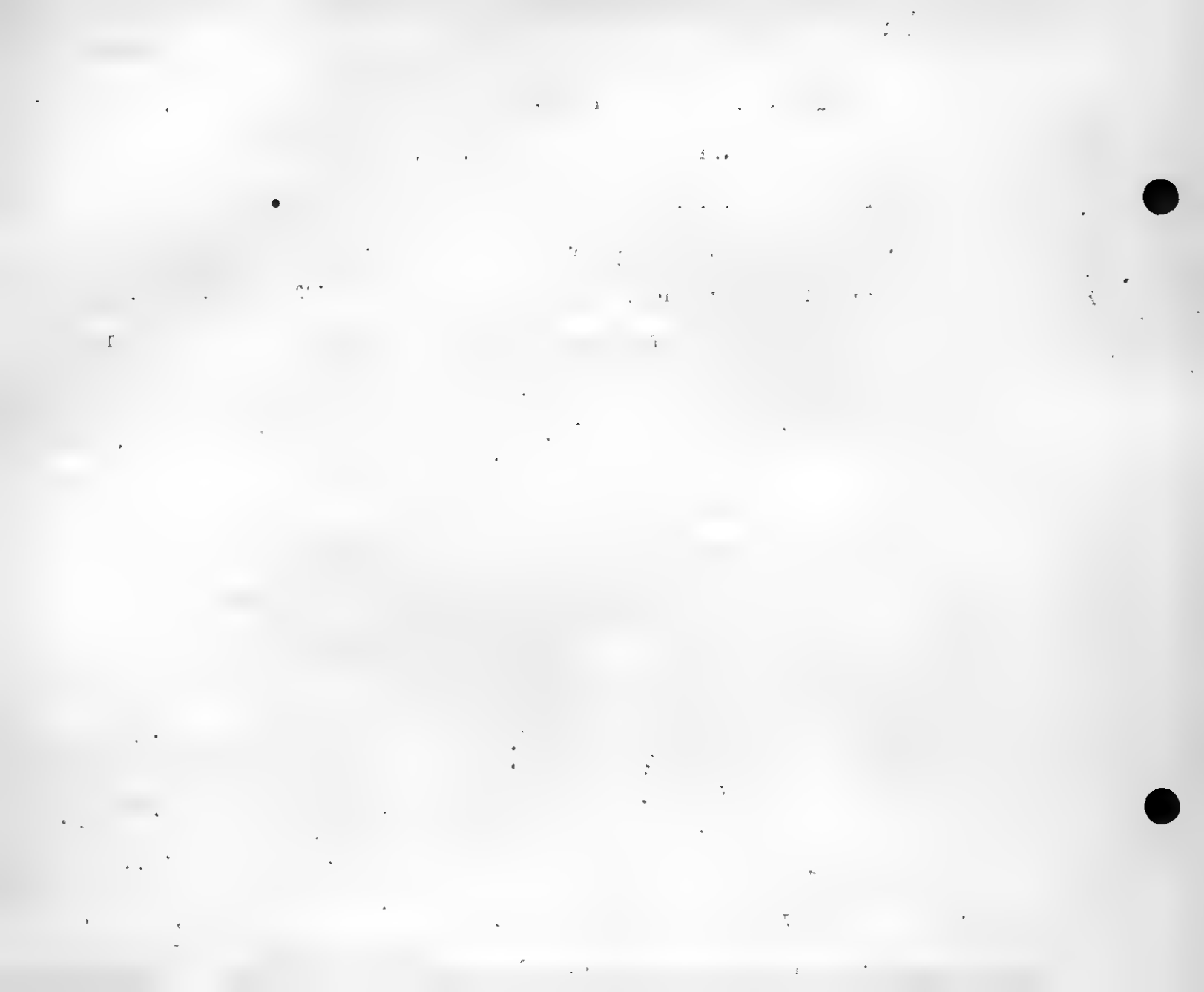


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 54  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Charles M.			Thompson			October 4, 1968			6:30 P M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS
Male		White		Feb. 18, 1884			84 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Virginia		U.S.A.					Baltimore, Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			Holly Hill Manor			Machinist			B&D
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
Maryland			Baltimore			Stoneleigh			632 Regester Ave.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Kilgy Thompson			Nannie Taylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
						F. Osborne Wilhelm			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from June 10, 1964, to Oct 4, 1968, that (I) (we) lost saw the deceased alive on Oct 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Laurence C. Post M.D.		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/5/68	
22d. PHYSICIAN'S NAME (Type)		LAURENCE C. Post		22e. ADDRESS 6205 York Rd - Baltimore 21212					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		10/7/68		Druid Ridge Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR Address				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson 1050 York Rd. 21204				OCT 8 1968		Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14150

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14159

1. NAME OF DECEASED  
(Type or Print)

VINTON. WALTER TUCKER

2. DATE AND HOUR OF DEATH

Oct. 28, 1968

10:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

6305 Banbury Road

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore Towson

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

6305 Banbury Road

5. SEX

male

6. RACE

caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

July 10, 1883

9. AGE (in years  
last birthday)

85

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
one during most of working life, even if retired)

Bakery salesman

10B. KIND OF BUSINESS OR INDUSTRY

retired

11. BIRTHPLACE (State or foreign country)

Anne Arundel Co, Md.

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

John Thomas Tucker

14. MOTHER'S MAIDEN NAME

Alice Ridgeway

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-09-2402

17. INFORMANT

Mrs. Elizabeth Gay; 6305 Banbury Rd.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

arteriosclerotic Cardio-  
vascular Disease

(B)

DUE TO, OR AS A CONSEQUENCE OF

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

22. I certify that (I) (this hospital) attended the deceased from MAY 1957 to Oct. 28 1968  
that (I) last saw the deceased alive on Oct. 28 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

M. K. Quinn MD

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

10/29/68

23C. PHYSICIAN'S  
NAME (Type)

Dr. M. Kevin Quinn

23D. ADDRESS

1927 York Road, Towson 4, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

24B. DATE

10/31/68

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 1 1968

25B. NAME OF REGISTRAR

Charles Judge

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc.-Baltimore, Md.

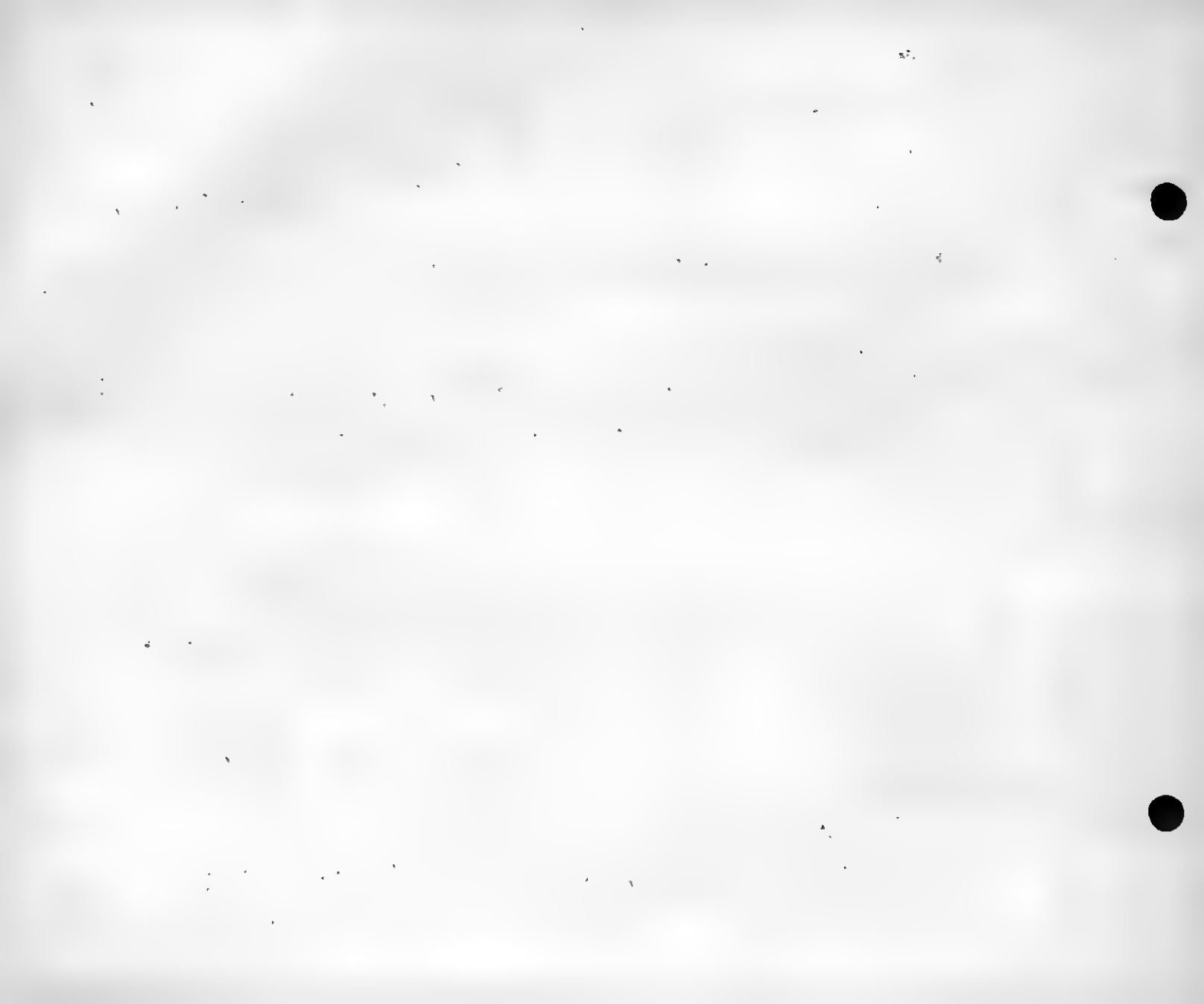
ADDRESS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for non-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>WILLIAM MCKINLEY TURNER</b>					2a. DATE OF DEATH Month <b>10</b> - Day <b>28</b> - Year <b>1968</b>			2b. HOUR <b>2 P. M.</b>	
3. SEX <b>M</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>4/22/1904</b>		6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County,</b> Md			
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson State Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kennington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>4005 Plyers Mill Rd.</b>	
14. FATHER'S NAME First <b>Marshall</b> Middle <b>Turner</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Cornelia</b> Middle <b></b> Last <b>Crawford.</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>579-09-5110</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIAL CEREBROVASCULAR DISEASE</b> <b>7/7/7</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b></b>		City or Town <b></b>		County <b></b> State <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/22/1968</b> , to <b>10/28/1968</b> , that (I) (we) last saw the deceased alive on <b>10/28/1968</b> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Newcomer</b>		DEGREE <b></b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		22e. ADDRESS <b>Mount Wilson, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PINEY ROCK CEMETERY</b>		23d. LOCATION (City or Town) <b>NELSON COUNTY, VIRGINIA</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>ROBERT L. SNOWDEN</b>				ADDRESS <b>ROCKVILLE, MD</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10152

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14161

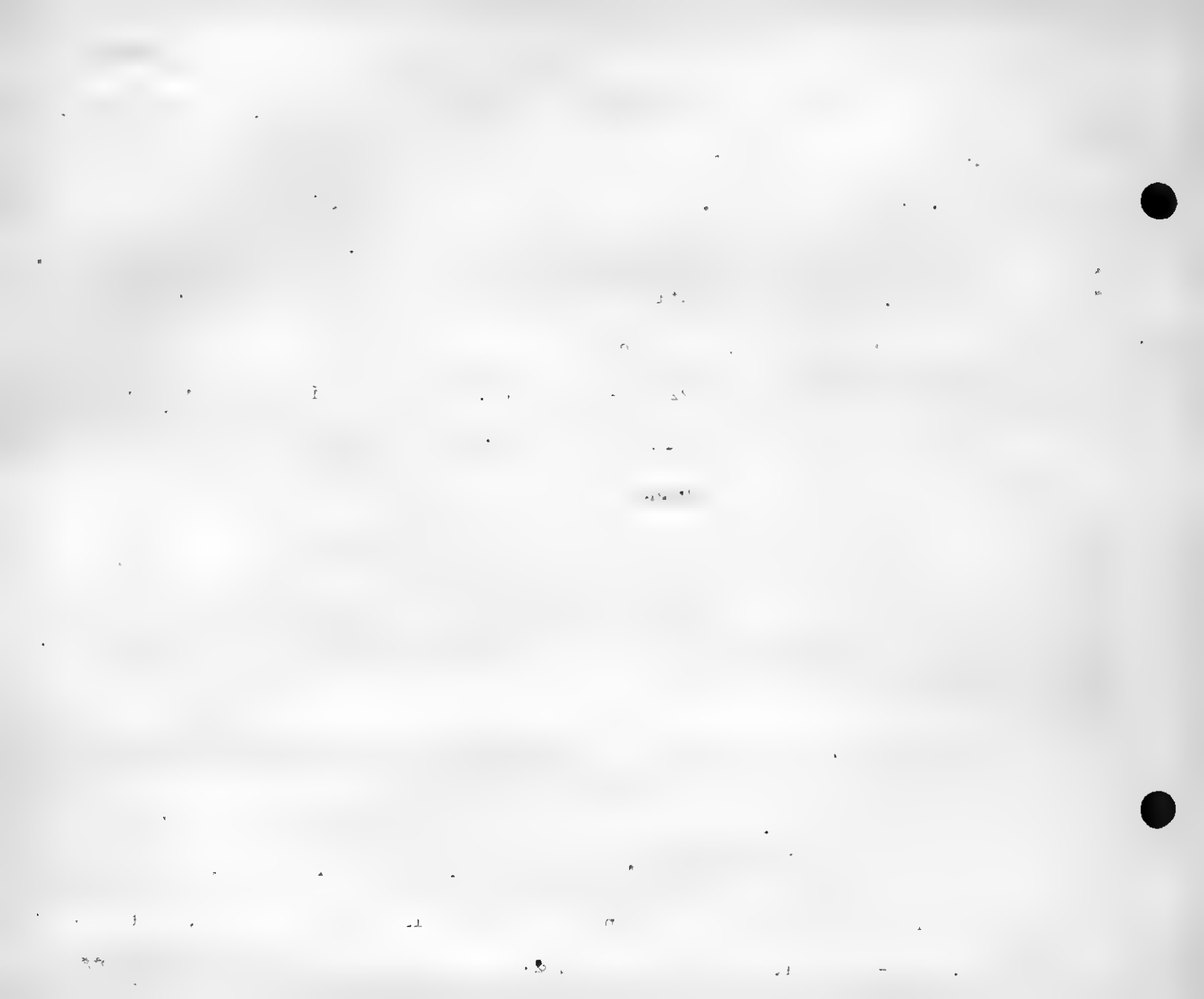
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
VICENT C. VACEK, JR.						<input checked="" type="checkbox"/> Month Day Year 10 11 1968			5:14p		
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	7 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	White	10/13/38	29 YRS	MONTHS	DAYS	Month Day Year October 11 1968			5:14mp		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.		
Balto. Md.		U.S.A.				Balto.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Draftsman-Koppers-Glen Arm					
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.						Balto.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER					
Vincent C. Vacek, Sr.			Marie Hajek			3417 E. Northern Pkwy.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
			217-34-3547			Betty L. Vacek (nec McLain) wife, above					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Craniocerebral injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				4:40 PM 10 11 19 68				Subject struck by station wagon			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
				Rd.				2900 Cub Hill Rd. Balto. Balto. Md.			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				October 12, 1968			
Ronald N. Kornblum, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				10/15/68		Holy Redeemer Cem.		Baltimore, Md.			
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc.						DATE		OCT 15 1968			
3331 Brehms Lane								J Charles Judge			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1-74  
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14153					14162				
1. DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
John Milton Vincent					Month 10 Day 8 Year 1968		8:50 A.M.		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		White		January 13, 1924		24 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore, Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		ST. JOSEPH HOSPITAL		Engineer		Self empl.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, Md. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		115 Northwood Dr.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Charles M. Vincent			Edna Morlock						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
Yes		WWII		Mrs. Bernita R. Vincent 115 Northwood Dr.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) advanced portal cirrhosis									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/7/1968, to 10/8/1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/8/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/8/68		
22d. PHYSICIAN'S NAME (Type) Ines Gilliani, M.D.					22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/11/68		Dulaney Valley Memorial		Cockeysville, Balto. Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson 1050 York Rd. 21204					OCT 9 1968		Charles Judge		

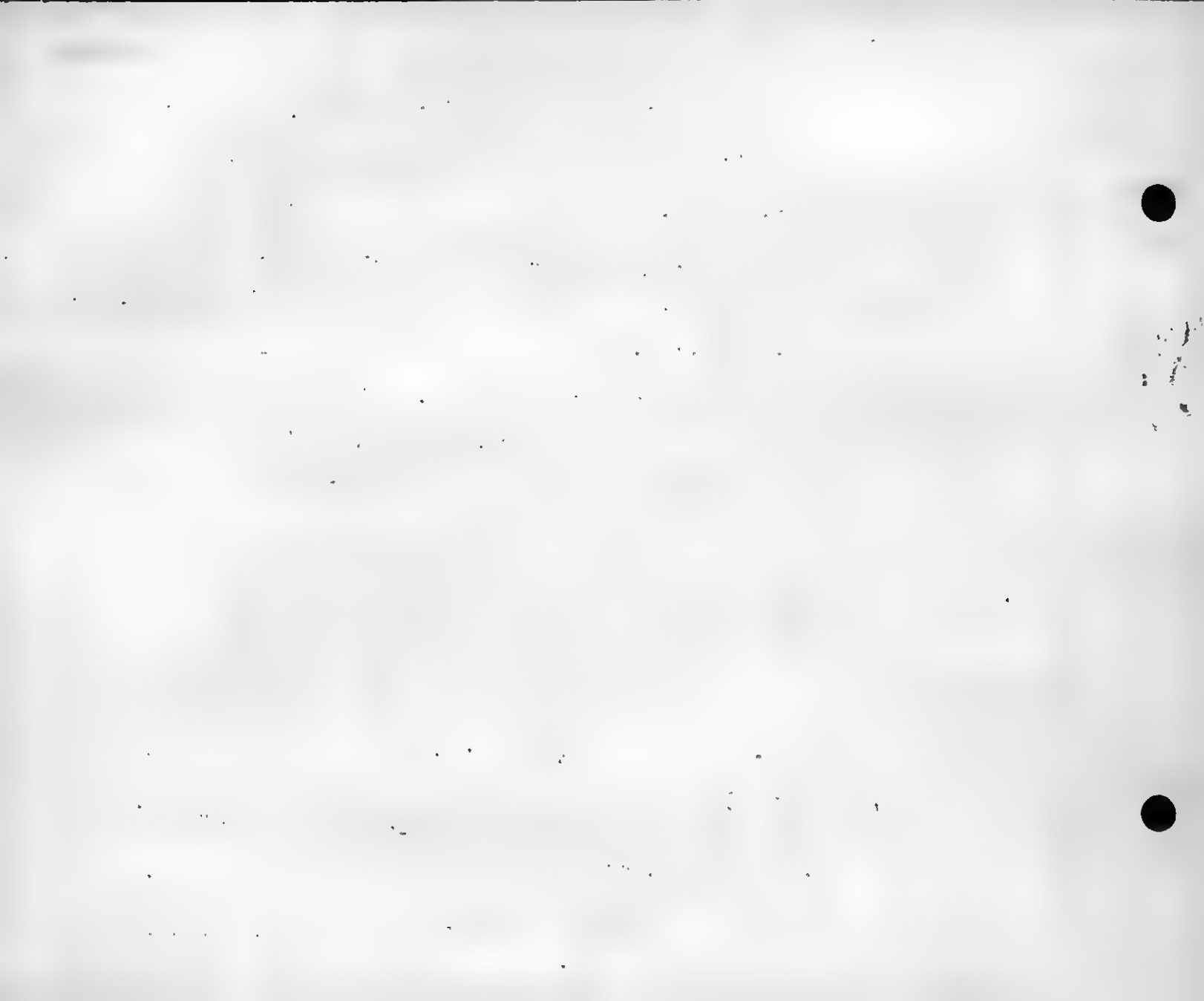




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> <div> <p>101154</p> <p>Item #6, Film G405 10/18/68 km</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>14163</p> </div> </div>											
1. DECEASED NAME (Type or print)						First		Middle		Last	
JOHN						H.		VOLZ, JR.			
2. DATE OF DEATH						Month		Day		Year	
Oct. 12, 1968											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		white		11/29/13		55 24 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Newport News, Va.				U.S.				Baltimore			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson				St. Josephs Hospital				Manager-Roberson Sinclair			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INS. OF CITY LIM. TS?		13e. STREET AND NUMBER	
Md.				Balto.		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Station 133 Cinder Rd. 21093	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
First Middle Last						First Middle Last					
John H. Volz, Sr.						Augusta Buck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no				213-09-8775		Ellen C. Volz (nee Casell) wife, above					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
4117 Myocardial Infarction											
DUE TO, OR AS A CONSEQUENCE OF (b)											
Coronary A.T.S. Dis.										5 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20c. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from January 1962, to Oct 12, 1968, that (I) (we) lost saw the deceased alive on Oct 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS.		22c. DATE SIGNED	
Dr. Charles E. Carr								<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		10/14/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Dr. Charles E. Carr						3900 N. Charles St.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				10/15/68		Baltimore Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Schimunek Funeral Home, Inc. 3331 Brehms Lane						OCT 15 1968		J Charles Judge			



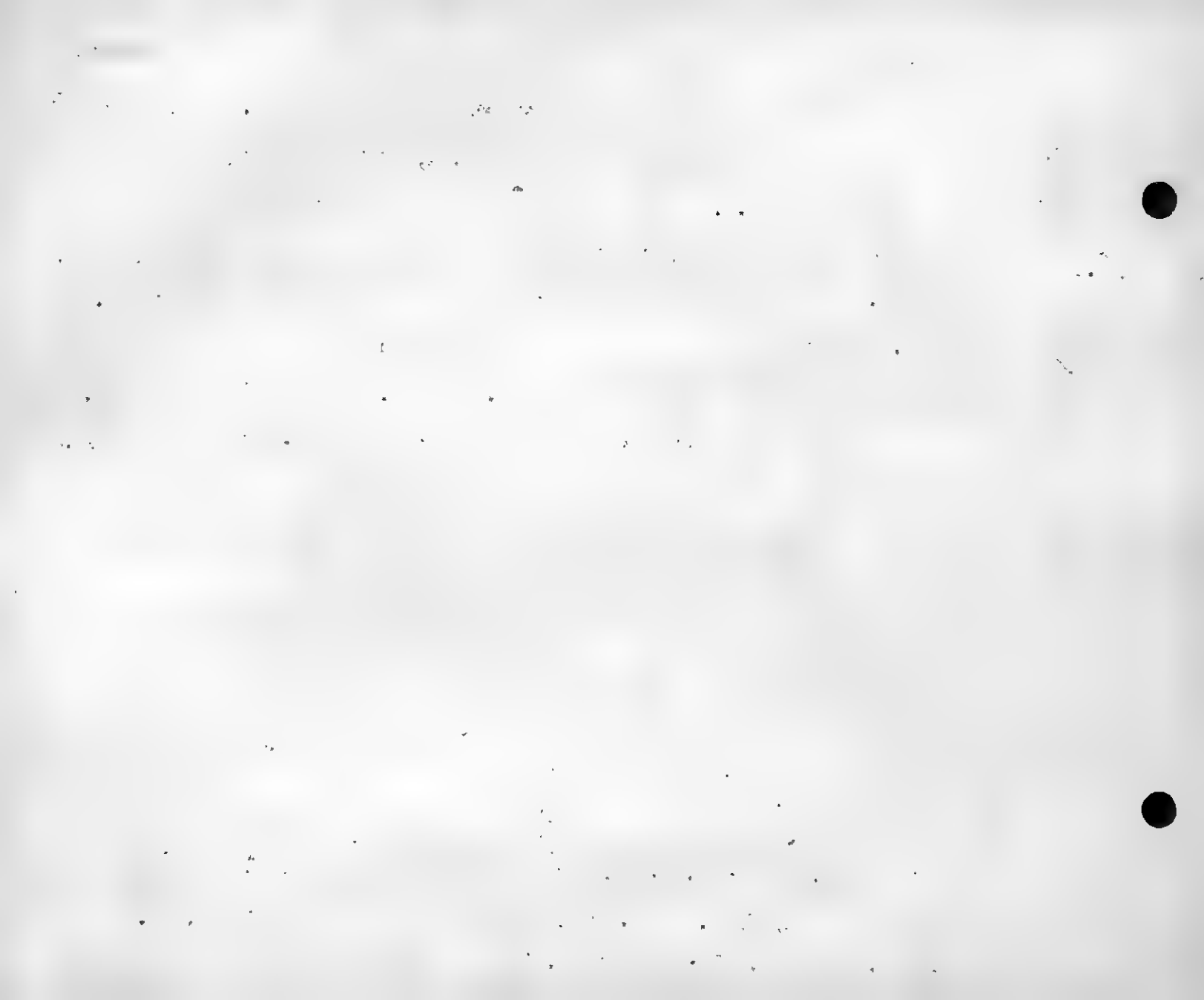
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VR A15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
141155					14164						
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Lester		H		Wagner				Month 10 Day 22 Year 68		6:00 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Dec. 4, 1893		74 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New York		U.S.A.				Baltimore				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Parkville		2704 Linwood Ave		Chief Property Officer		Edgewood					
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Balto		Parkville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2704 Linwood Ave.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Harry P. Wagner								Nettie Yung			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes, no, or unknown		220207826		Mrs. Elsie M. Wagner		2704 Linwood Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u>										Several years	
4127 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , 19 <u>67</u> , to <u>Oct.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>October 20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Loy M. Zimmerman M.D.		10/23/68		Loy M. Zimmerman M.D.		3202 Harford Rd Baltimore Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		10/25/68.		Parkwood Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck Inc.		5305 Harford Rd. #14		OCT 23 1968		Charles Judge					

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

14165

1. DECEASED-NAME (Type or print) <b>Garner A. Ward</b>			2a. DATE OF DEATH Oct 9, 1968			2b. HOUR 12:30 PM				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>3-25-1892</b>		6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shangri-La N.H.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Realtor - Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY, J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>5103 Wetheredsville Road</b>		
14. FATHER'S NAME First Middle Last <b>Benjamin Ward</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Navella Rippon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b. SOCIAL SECURITY NO <b>218-09-8689</b>		17. INFORMANT Address <b>Grace Sraver-6405 Lehnert Rd. 21207</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4107</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7+</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>16 July, 1962</b> , to <b>9 Oct, 1968</b> , that (I) (we) last saw the deceased alive on <b>22 Aug 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Irwin H. Moss, M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/11/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Irwin H. Moss, M.D.</b>				22e. ADDRESS <b>5836 Westview Mall Baltimore, Maryland 21228</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hghts. Ave</b>				25a. BY REGISTRATION <b>Oct 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2



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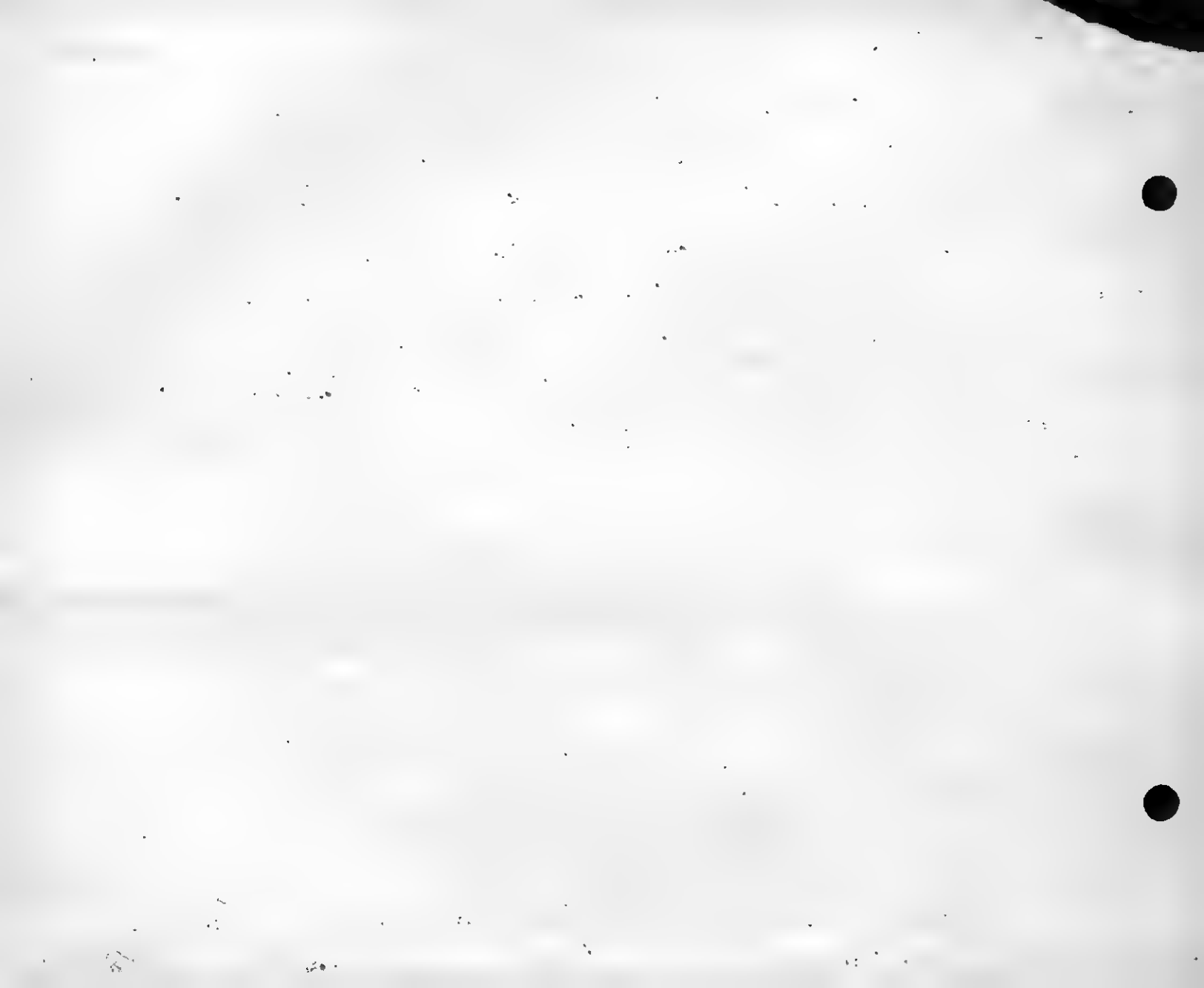
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CERTIFICATE OF DEATH

14157

14166

1 DECEASED NAME (Type or print) <b>Pauline Ellen Watkins</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR M			
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>July 26, 1891</b>		6 AGE (In years last birthday) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3300 FAIRVIEW Rd</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3300 FAIRVIEW Rd</b>	
14 FATHER'S NAME First <b>Albert</b> Middle <b>Abe</b> Last <b>UNKNOWN</b>			15 MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. <b>—</b>		17 INFORMANT <b>Mildred Kelch - Route 4, Edgewater, MD 21037</b>		Address <b>Bul 278</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malignancy - Breast - metastasis</b> <b>174x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>170x</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>10/29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William M. P.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/30/68</b>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD</b>			
24. FUNERAL DIRECTOR <b>Elsworth Armagost - 4600 Liberty Heights Ave.</b>				25a. RECEIVED BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

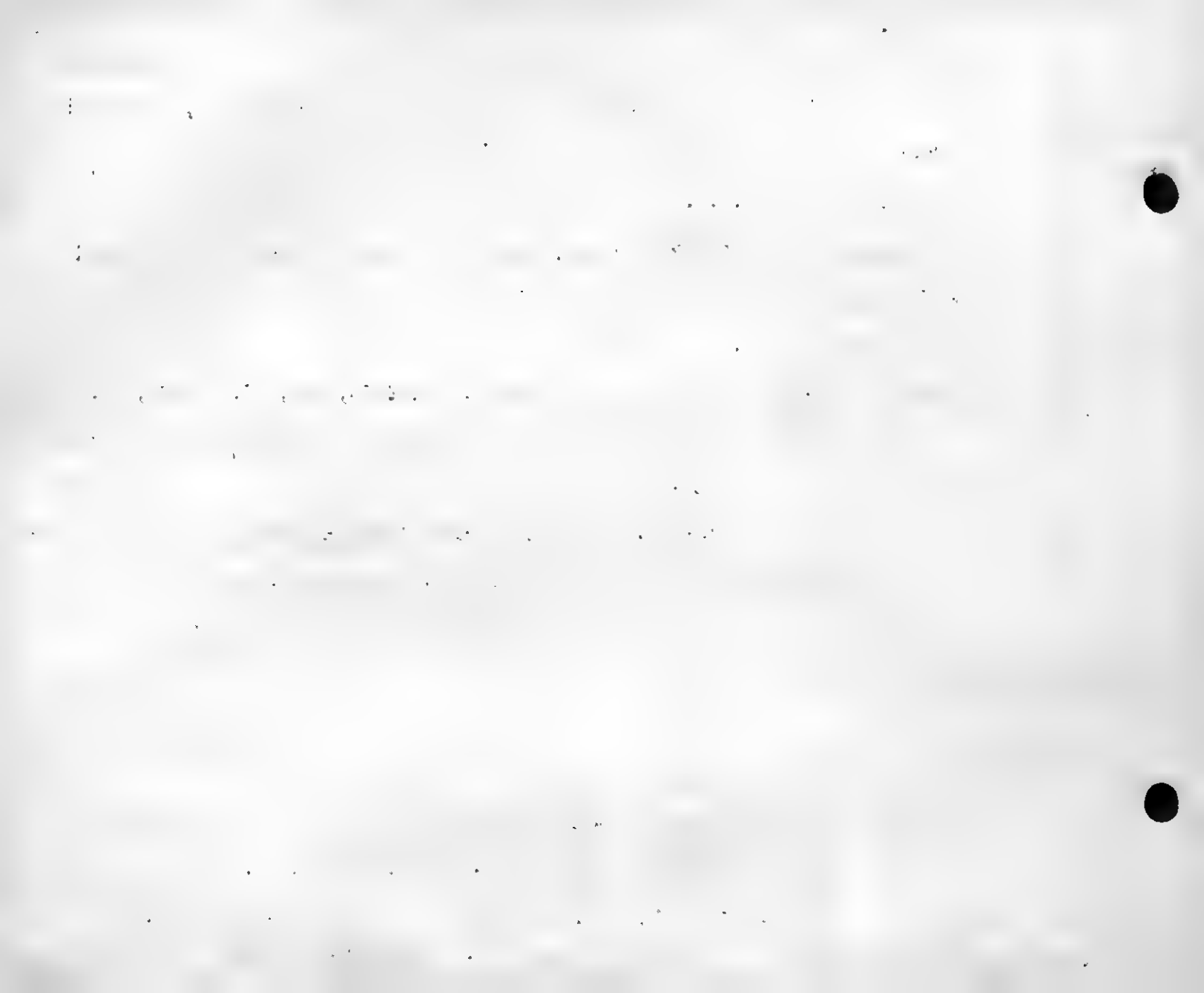




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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
CHARLES WALLACE WEBB						OCTOBER 24, 1968			10:20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
MALE		WHITE		10/11/18		50 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				BALTIMORE Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VETERANS ADMIN. HOSPITAL			MACHINE ADJUSTOR		STATIONERY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND					BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4118 ARDLEY AVENUE	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
GEORGE D. WEBB						ELEANOR - - BRADY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES			WWII		212 07 80 74 CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL, UNDETERMINED ORGANISM									DAYS	
DUE TO, OR AS A CONSEQUENCE OF (b) ENCEPHALOMALACIA, RIGHT									UNKNOWN	
DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS, BASILAR ARTERY OCCLUSION									UNKNOWN	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) LAENNEC'S CIRRHOSIS. DIABETES MELLITUS. ARTERIOSCLEROTIC HEART DISEASE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (this hospital) attended the deceased from OCT 23, 1968, to OCT 24, 1968, that (we) lost the deceased alive on OCT 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did) (did not) view the body after death.										
22b. SIGNATURE He'lon Neilson He						DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/25/68		
22d. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.						22e. ADDRESS VAH, FT. HOWARD, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		10/28/68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR Robert C. Altenburg										
25a. REC'D BY REGISTRAR ROBERT C. ALTENBURG FUNERAL HOME 8/19/68										
25b. REGISTRAR'S SIGNATURE Charles Judge										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

118

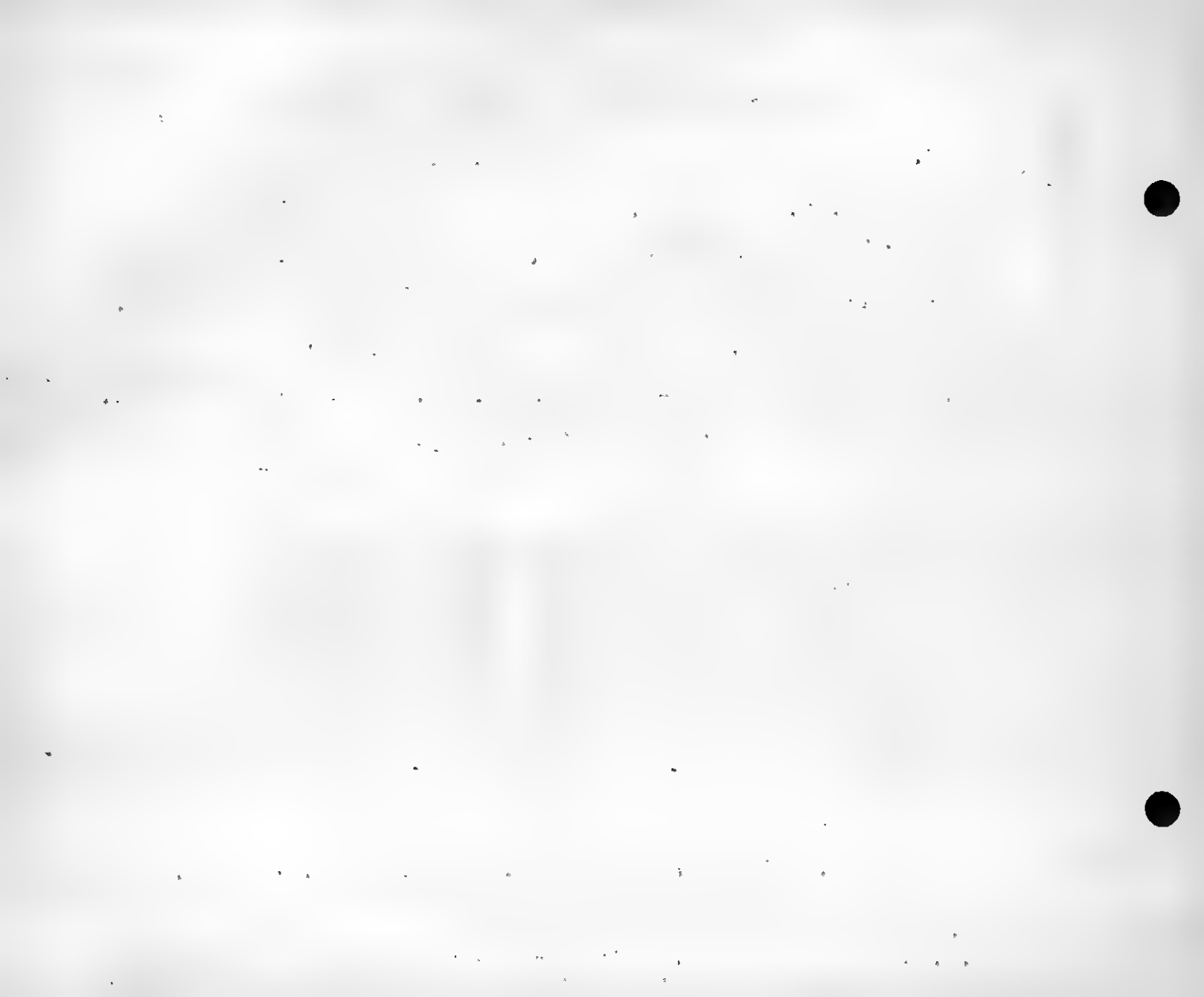
14159

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14168

1 DECEASED-NAME (Type or print) <b>Marvin Elco Webb</b>			2a DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1968</b>			2b HOUR <b>3 P. M.</b>	
3 SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Nov. 7, 1891</b>		6. AGE (in years lost birthday) <b>76</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>Madison Cty. Ga.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Lutherville</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>404 Towson Ave.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Georgia</b>		13b COUNTY <b>Bowman</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>North Broad St.</b>	
4 FATHER'S NAME First Middle Last <b>Robert F. Webb</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes give war or dates of service) <b>WWI</b>		16b SOCIAL SECURITY NO. <b>257-28-0904</b>		17. INFORMANT Address <b>Robert M. Webb, 404 Towson Ave.</b>	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Parkinsonism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-13, 1963</b> , to <b>10-24, 1968</b> , that (I) (we) last saw the deceased alive on <b>10-22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alfred G. Ossman, Jr.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Alfred G. Ossman, Jr.</b>				22e ADDRESS <b>1101 St. Paul St.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		23b. DATE <b>10/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		23d. LOCATION (City or Town) (County) (State) <b>Bowman Ga.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>				25a REC'D BY REGISTRAR <b>OCT 25 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



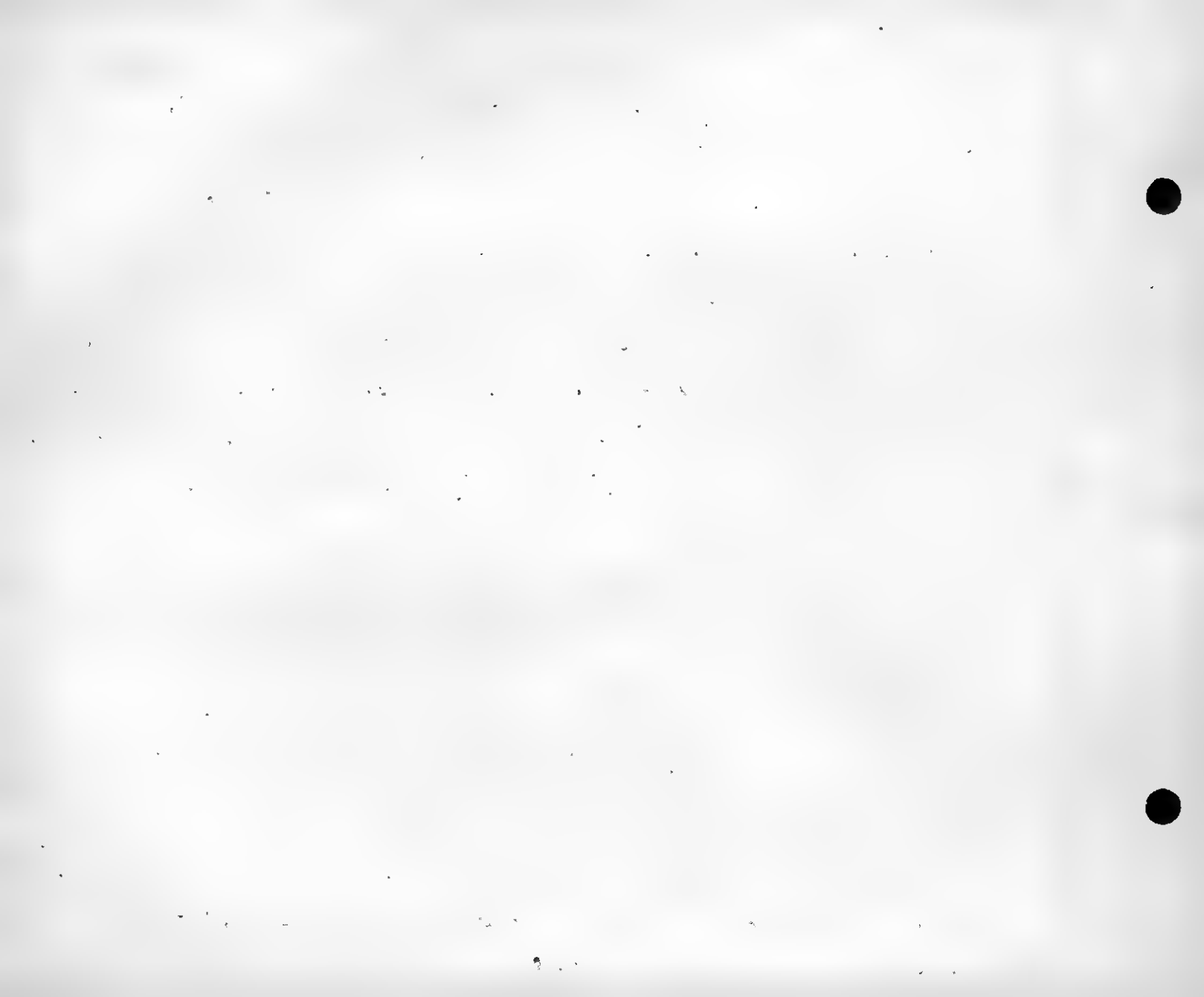
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		14169		2b. HOUR		
George		L.	Webster		Month Day Year October 7, 1968				4:30 P.M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS		
Male	White		May 19, 1897		71 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Scotland	U.S.A.				Baltimore				Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Lutherville		14 W. Seminary Ave.		Teacher							
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Baltimore		Lutherville				14 W. Seminary Ave.			
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last					
Alexander		Webster		Elizabeth		McIntyre					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WWI		17. INFORMANT		Address					
		219-01-6884		Mrs. Naomi Webster		14 W. Seminary Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Primary Carcinoma left lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>6 yrs.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 5, 1968</u> , to <u>Oct. 7, 1968</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Oct. 2, 1968</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Earl L. Chambers M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/8/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		22e. ADDRESS <u>160 W. Cold Spring</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/10/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

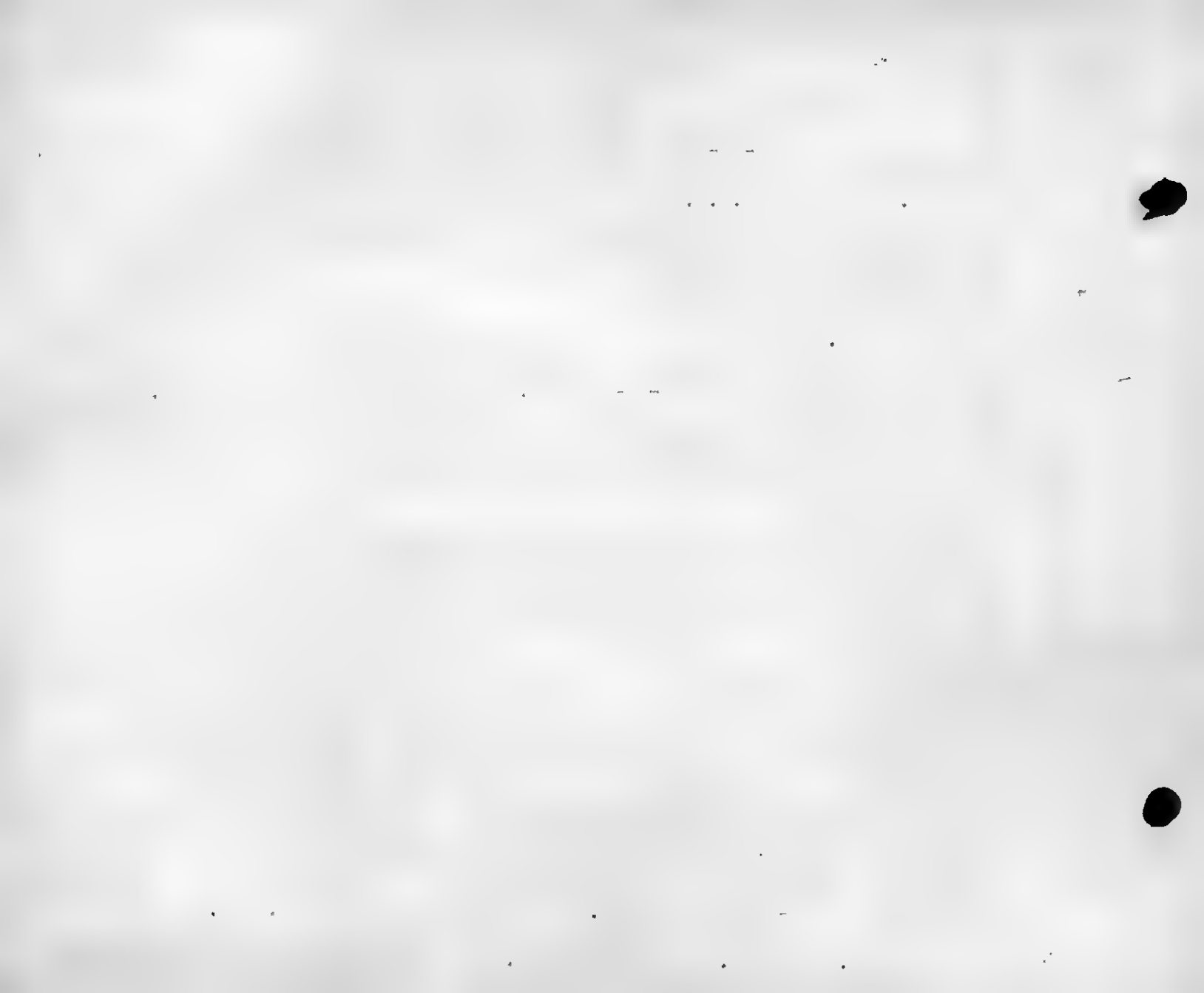
11162

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14170

1. DECEASED-NAME (Type or Print)		First	Middle	Last	(WEEKS)	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year	2b. HOUR P.M.
RUTH		BAKER		WEEKS		<input checked="" type="checkbox"/> 10/25/68 19	2:00 P.M.
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR P.M.
female	white	1-20-12	56 YRS.			October 25, 1968	2:00 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Md.		U.S.A.				Baltimore Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. LSUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore County		Giant Super Market Loch Raven & Taylor Avenues		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore				13e. STREET AND NUMBER 6111 Moyer Avenue	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
John F. Ellis				Carrie Straysinger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS			
No		216-14-3837		C. Kenneth Weeks, 6111 Moyer Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic and Hypertensive Cardiovascular</u> 1120 <del>DIKOR OF SYMPTOM</del> Disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) _____ DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		10/26/68	
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		10-29-68		Gdns. of Faith		Balto., Md.	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc., 5305 Harford Rd.				DATE OCT 28 1968		Charles Judge	





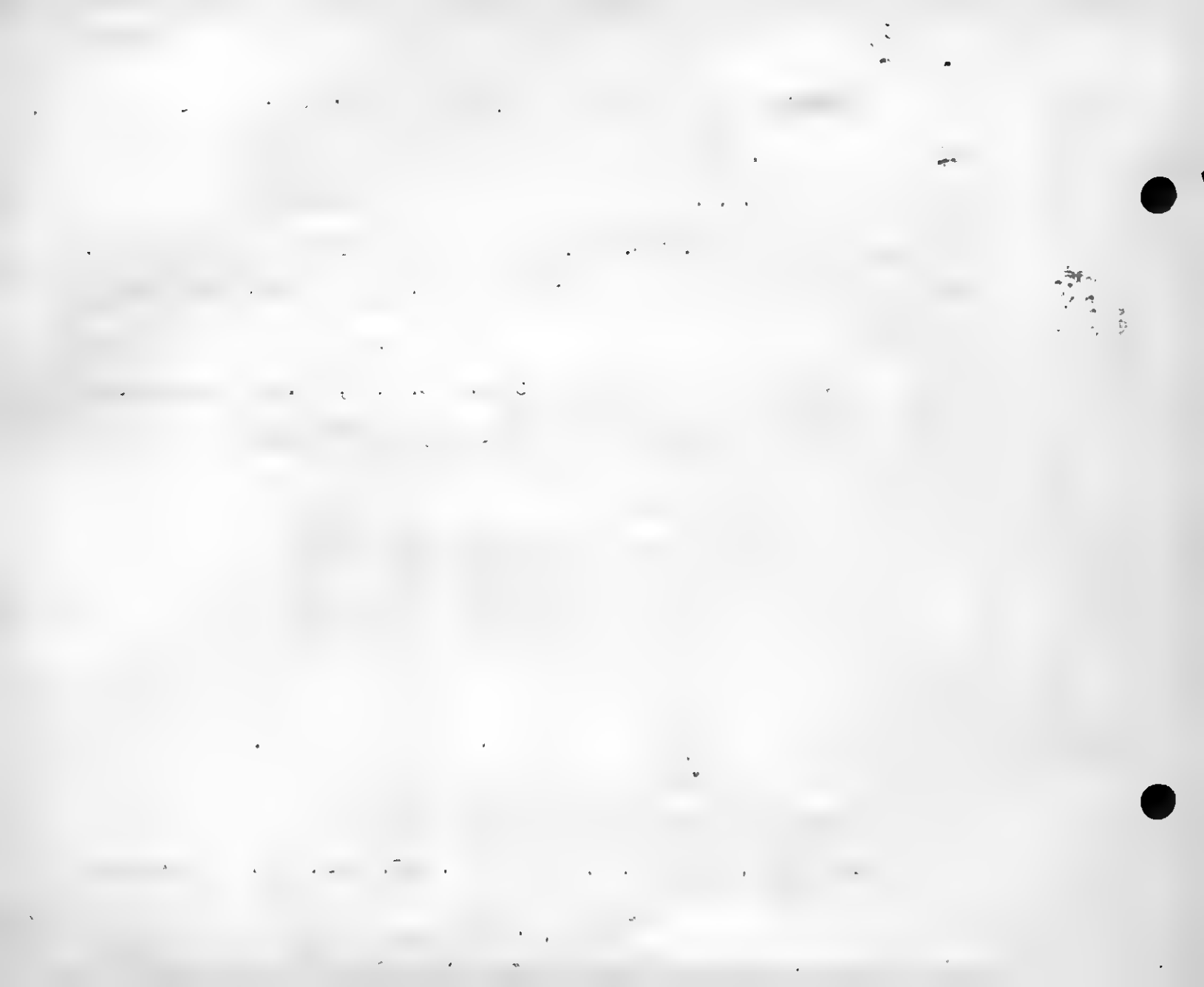
CERTIFICATE OF DEATH

10162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>AUGUST</b>		First <b>JOHN</b>		Middle <b>WEIS</b>		Last <b>WEIS</b>		20. DATE OF DEATH Month <b>OCTOBER</b>		Day <b>17</b>		Year <b>1968</b>		2b. HOUR <b>4:05</b>		p. <b>p.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12 11 08</b>				6. AGE (in years lost birthday) <b>59</b>		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN.			
7a. BIRTH-PLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>BALTIMORE</b>				Md					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>ATTENDANT</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>CITY</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>				13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>405 MONTFORD AVENUE</b>					
14. FATHER'S NAME <b>ADAM WEIS</b>				First <b>ADAM</b>				Middle <b>WEIS</b>				Last <b>WEIS</b>					
15. MOTHER'S MAIDEN NAME <b>MARY STERN</b>				First <b>MARY</b>				Middle <b>STERN</b>				Last <b>STERN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>215 03 9205</b>				17. INFORMANT <b>CLIN. REC., VAH, FORT HOWARD, MARYLAND</b>				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA, RECTO-SIGMOID, FAR ADVANCED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 MONTHS</b>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or RFD No City or Town County State									
22a. I certify that (X) (this hospital) attended the deceased from <b>Oct. 8</b> , 1968, to <b>Oct. 17</b> , 1968, that (X) (we) last saw the deceased alive on <b>October 17</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Alfonso A. Lopez</b>												DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10 17 68</b>			
22d. PHYSICIAN'S NAME (Type) <b>ALFONSO A. LOPEZ, M. D.</b>												22e. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>					
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>				23b. DATE <b>10-21-68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>				23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>					
24. FUNERAL DIRECTOR <b>Robert A. Miller</b> 2334 Jefferson St. Baltimore, Md.																	
25a. RECD BY REGISTRAR <b>OCT 22 1968</b>												25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M  
10M REV 1-68

11163

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14172

1 DECEASED-NAME (Type or Print) <b>WILLIAM</b>		First <b>Thomas</b>		Middle <b>Thomas</b>		Last <b>Welch</b>		2a. DATE KNOWN OF DEATH EST. MATED <input type="checkbox"/> <b>Oct. 13, 1968</b>		2b. HOUR <b>5:00 PM</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>Sept 21 1902</b>	6. AGE (In years last birthday) <b>66</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Oct.</b> Day <b>13,</b> Year <b>1968</b>		2d. HOUR <b>5:00 PM</b>			
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>					
10. CITY OR TOWN OF DEATH <b>UNK? Woodlawn</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5601 Windsor Mill Rd Union Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Weaver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) <b>Md ??</b>		13b. COUNTY <b>??</b>		13c. CITY OR TOWN <b>?? Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>UNK? 1501 Cox St</b>			
14. FATHER'S NAME <b>Thomas William Welch</b>		First <b>Thomas</b>		Middle <b>William</b>		Last <b>Welch</b>		15. MOTHER'S MAIDEN NAME <b>Caroline Myers</b>		First <b>Caroline</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO (If yes give year or dates of service) <b>21403 5320</b>		17. INFORMANT <b>Mildred Welch</b>		ADDRESS <b>1501 Cox St Balto 21211</b>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epilepsy</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on <b>Autopsy <input checked="" type="checkbox"/></b> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes <input checked="" type="checkbox"/></b> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Edward F. Wilson, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town or county)				22b. DATE SIGNED <b>October 14, 1968</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>Oct 17 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's (Hampden)</b>			
23d. LOCATION (City or Town) (County) (State) <b>Balto Md</b>				23e. REC'D BY REGISTRAR <b>Oct 21 1968</b>				23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
24. FUNERAL DIRECTOR <b>Burgee Funeral Home Balto Md</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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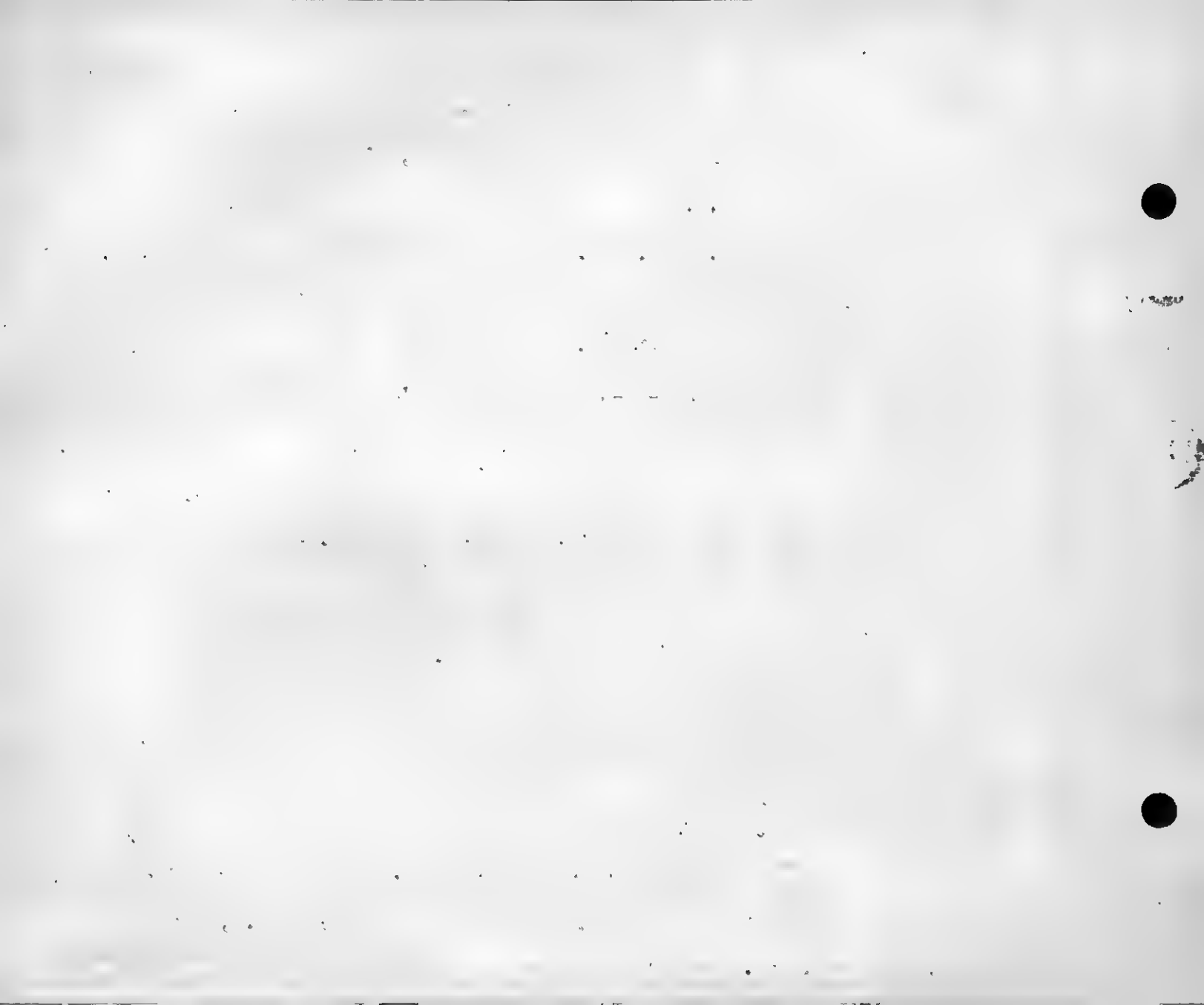
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14164

14173

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
Lyell		E		Wellmeyer Sr	10 9 68				
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male	White		April 10, 1901		67 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Iowa		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Gr. Balto. Med. Center		Foreman		Beth. Steel			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Baltimore				3624 Delverne Rd	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
George		Wellmeyer		Amanda Sage					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes		213-09-3893		Mrs Naomi L Wellmeyer		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Septic static pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pathologic fracture left femur</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of the prostate.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 mos</u> <u>1 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
6/10/68		pathologic fracture of femur		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		no			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-10-68</u> , 19 <u>68</u> , to <u>10-8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
John J. Fahey		John J. Fahey, M. D.		1117 St. Paul Street, Baltimore		10-11-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/12/68		Parkwood		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore Maryland				OCT 11 1968		Charles Judge			



16165

CERTIFICATE OF DEATH

14174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
JOSEPHUS LEONARD WELSH						Month	Day	Year	5:15 PM	
3 SEX	M		4. RACE	W		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS
						2-17-91		77 YRS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.			U.S.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore			SPRING GROVE S. Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.			Pr. Geo.		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		8141-15th ave. (Md)	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
CHARLES E WELSH						LOTTA			Bump	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address	
NO			577-03-1032A			Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>										
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) <u>Myocardial Infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Sequelae of arteriosclerotic heart disease</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4111										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-17, 1966</u> to <u>10/30, 1968</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>10-30, 1968</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.										
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
<u>Evelio A. Felipe MD</u>										<u>10/30/68</u>
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
EVELIO A. FELIPE MD						SPRING-GROVE-STATE HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			NOV 9, 1968		FORT LINCOLN CEM			COLMAR MANOR, MARYLAND		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. N. CHAMBERS & Co. RIVERDALE, MD.						DATE NOV 4 1968		Charles Judge		





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14166

CERTIFICATE OF DEATH

14175

1. DECEASED NAME (Type or print) <b>Robert</b>		First	Middle	Last	2a. DATE OF DEATH Month <b>Oct.</b> Day <b>8</b> Year <b>1968</b>		2b. HOUR <b>6 AM</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 29, 1901</b>		6. AGE (in years last birthday) <b>67</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5743 Edmonson Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Peabody - Danville on Street</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>See 12a</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Robert</b>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Jennie May</b>		Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>942</b>		17. INFORMANT <b>Fay May Braun</b>		Address <b>Montpelier St 2/2/18</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>und</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1519</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1 Apr</b> , 19 <b>67</b> , to <b>8 Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9 Oct</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Goodman</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>30 Oct 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM GOODMAN, MD</b>		22e. ADDRESS <b>1334 Sulphur Spring Rd - 21227</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct 15 - 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woods Cross Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co -</b>	
24. FUNERAL DIRECTOR <b>CURTIS E. EVANS</b>		ADDRESS <b>14005 Chesapeake</b>		25a. REC'D BY REGISTRAR <b>DA</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



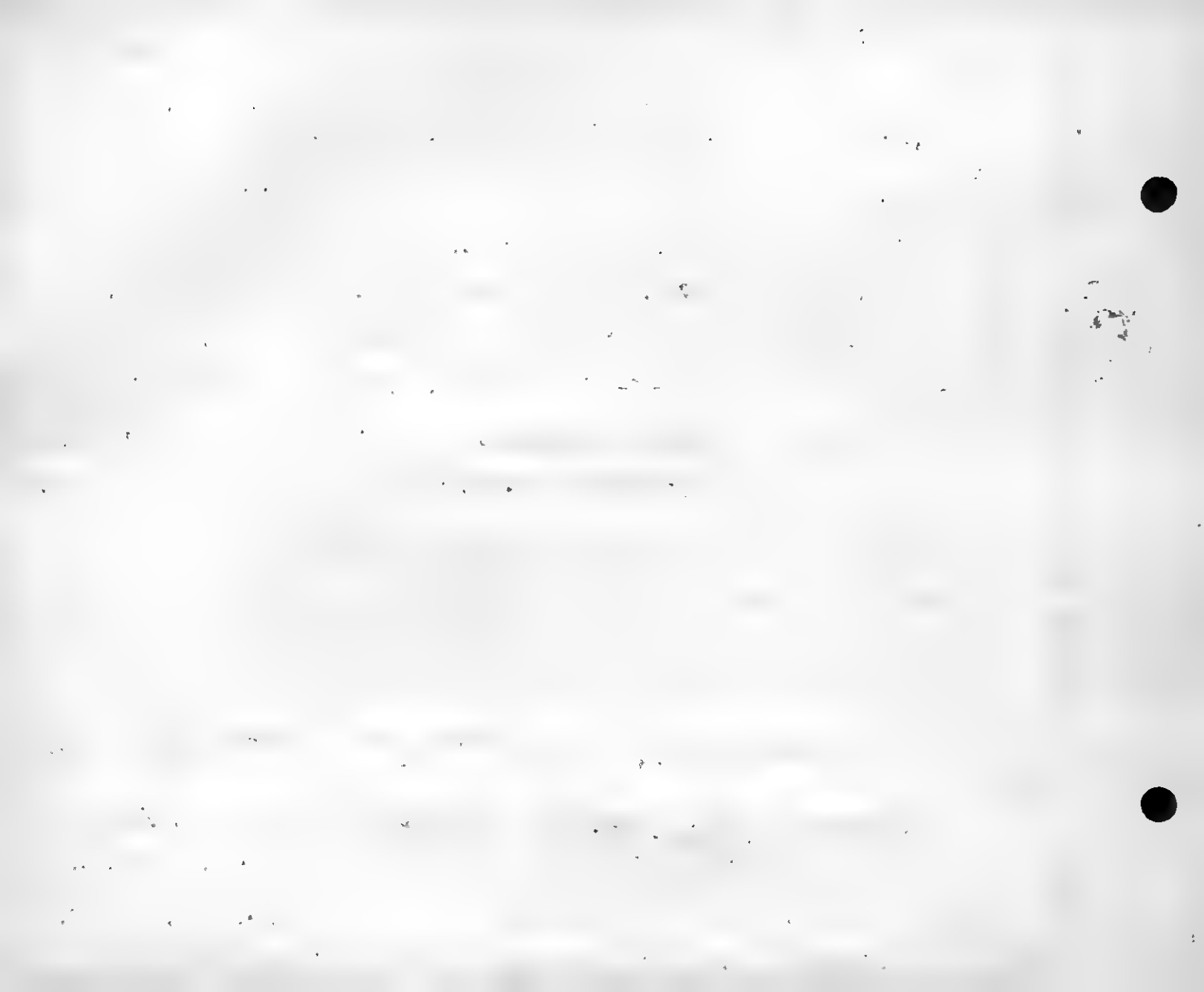
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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First <b>Luella</b>	Middle <b>M.</b>	Last <b>Whitekettle</b>	2a. DATE OF DEATH Month <b>Oct.</b> Day <b>28</b> , Year <b>1968</b>			2b. HOUR <b>M.</b>
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>January 11, 1901</b>		6. AGE (In years last birthday) <b>67</b> YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Thornleigh</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1809 Templeton Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Thornleigh</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1609 Templeton Rd.</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>A.</b> Last <b>Smith</b>			15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>E.</b> Last <b>Davis</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>161-03-5782B</b>		17. INFORMANT Address <b>Howard C. Whitekettle 1609 Templeton Rd. #4</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UTERINE CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>2 YEARS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>174X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the physician) attended the deceased from <b>10/18</b> , 19 <b>68</b> , to <b>10/26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Donald L. Sommerville, M.D.</b>					DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/28/68</b>
22d. PHYSICIAN'S NAME (Type) <b>Dr. Donald Sommerville</b>					22e. ADDRESS <b>25 W. Penna. Ave. Towson, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>			23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Road Balto., Md. 21212</b>					25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

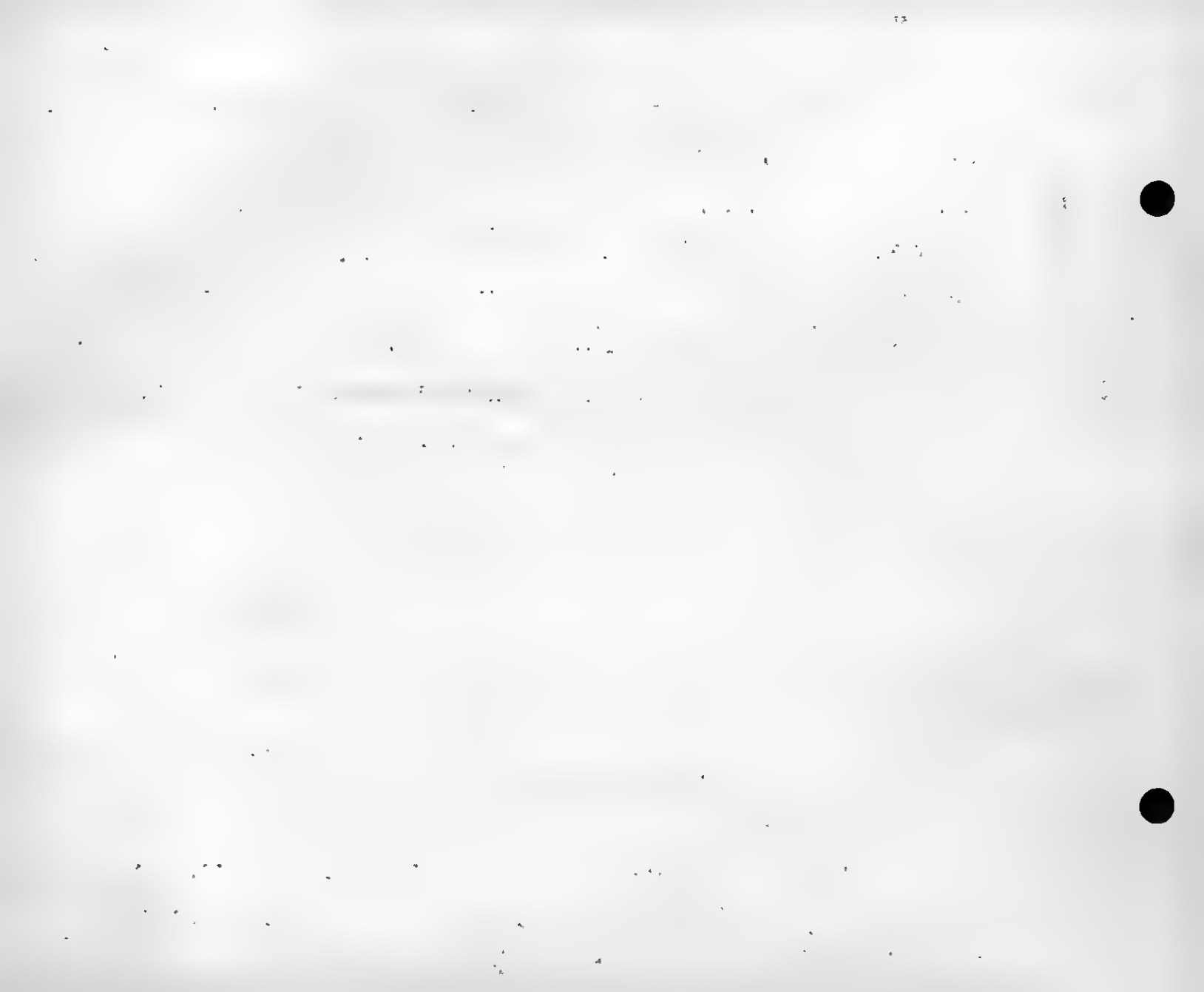
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
141168									
14177									
1. DECEASED NAME (Type or print) <b>G. Raymond Wilhelm</b>					2a. DATE OF DEATH Month <b>Oct</b> Day <b>7</b> Year <b>1968</b>		2b. HOUR <b>5:30 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 24, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>			
10. CITY OR TOWN OF DEATH <b>Upperce</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RD</b>		12a. USUAL OCCUPATION (Kind of work done during most of work as life, even if retired) <b>Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. G&amp;E</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Parkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD</b>	
14. FATHER'S NAME First Middle Last <b>George W. Wilhelm</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida V. Hale</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>NO</b> (unknown)		16b. SOCIAL SECURITY NO. <b>212-05-4116</b>		17. INFORMANT Address <b>Charlotte Wilhelm Parkton, Md. (Wife)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Porta Craniy Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Midway</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>401</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 7</u> , 1968, to <u>Oct 7</u> , 1968, that (I) (we) last saw the deceased alive on <u>Oct 7</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph E. Bush</u>					DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-7-68</b>
22d. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush MD</b>					22e. ADDRESS <b>HAMPSTEAD MD</b>				
23a. BURIAL, CREMATION, REBURY <b>Burial</b>		23b. DATE <b>Oct. 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Upperce, Balto. Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home</b>					ADDRESS <b>Hampstead, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 10 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
14178										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
ALBERT			-			WILLIAMS		Month Day Year OCTOBER 25, 1968		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		NEGROID		7 3 20		48 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
N.C.		U.S.A.				BALTIMORE,				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			HOSPITAL VETERANS ADMINISTRATION			TRUCK DRIVER		CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND					BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1028 N BROADWAY	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
WILLIE			WILLIAMS			DAVIS BROWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES			WWII		244 18 5935 CLINICAL RECORDS, VA HOSP, FT HOWARD, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF RT LUNG WITH METASTASIS										
1621 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
1621										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 9/9/68, 19__, to 10/25/68, 19__, that (X) (we) last saw the deceased alive on 10/25/68, 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		22c. DATE SIGNED		
Sung Ill Shin M.D.						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		10 26 68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
SUNG ILL SHIN, M.D.						VA HOSPITAL, FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		10/27/68		BALTIMORE NATIONAL		BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR ADDRESS				25a. APPROVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
ELLIOTT FUNERAL HOME, 1129 N CAROLIN ST, BALTO, MD.				NOV 8 1968		DATE				





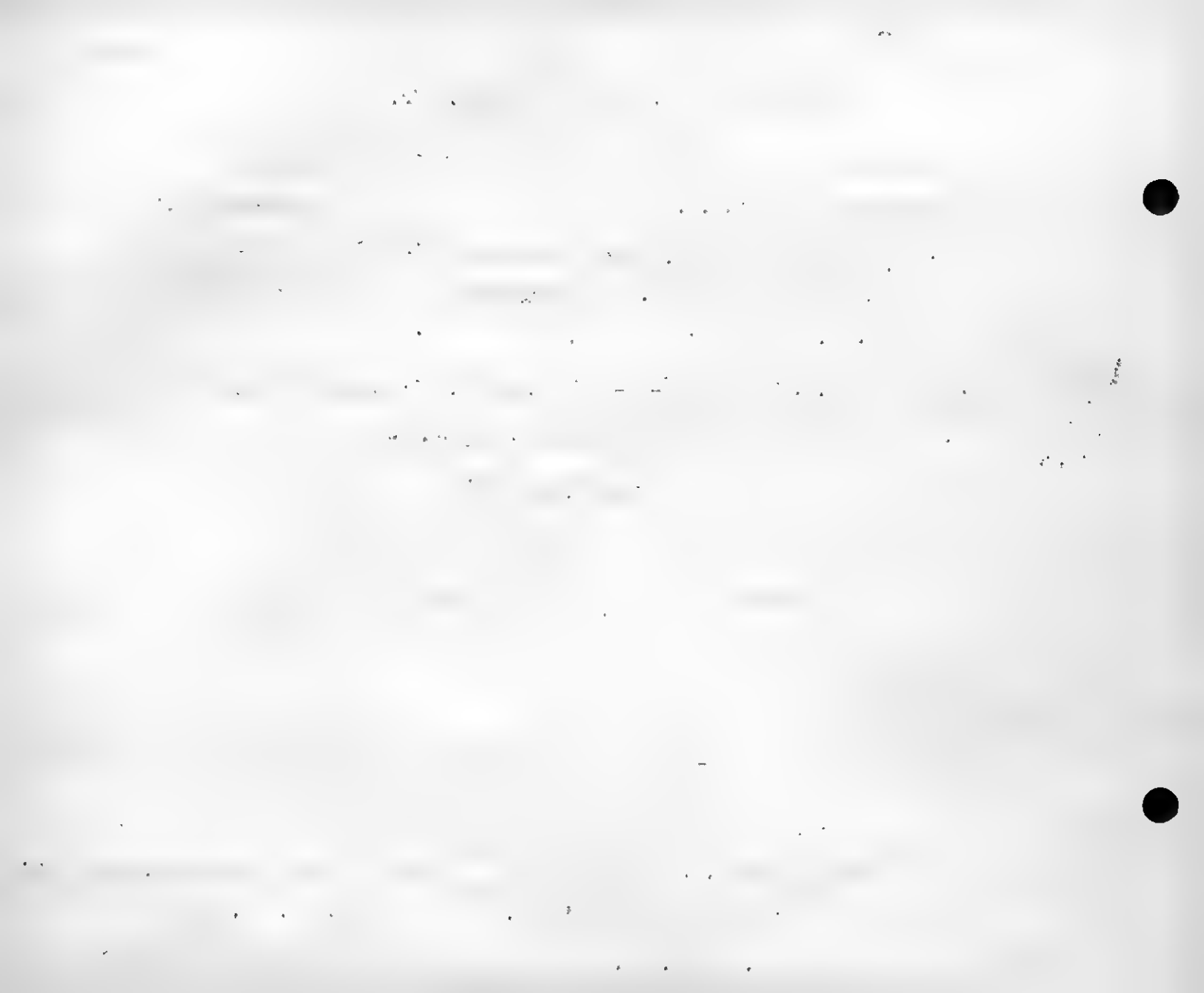
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VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
14170									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
John B. Williams Jr.						Month Day Year 10 7 68			2:45 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
male		white		3-5-17		51 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Co. Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		Trucking		Self-employed			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Balto.		Baltimore				3301 Aeton Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last John B. Williams Sr.			First Middle Last Emma Rogers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			W.W. 2		Mary E. Williams		same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
While <input type="checkbox"/> Not while <input type="checkbox"/>									
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10-7</u> , 19 <u>68</u> , to <u>10-7</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-7-68</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Samuel Lee, M.D.								10-7-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Samuel Lee, M.D.				7620 York Road, Baltimore, Md. 21204					
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		10/10/68		Parkwood Cem.		Balto. Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck Inc. Balto. Md.						OCT 8 1968		Charles Judge	

MEDICAL CERTIFICATION

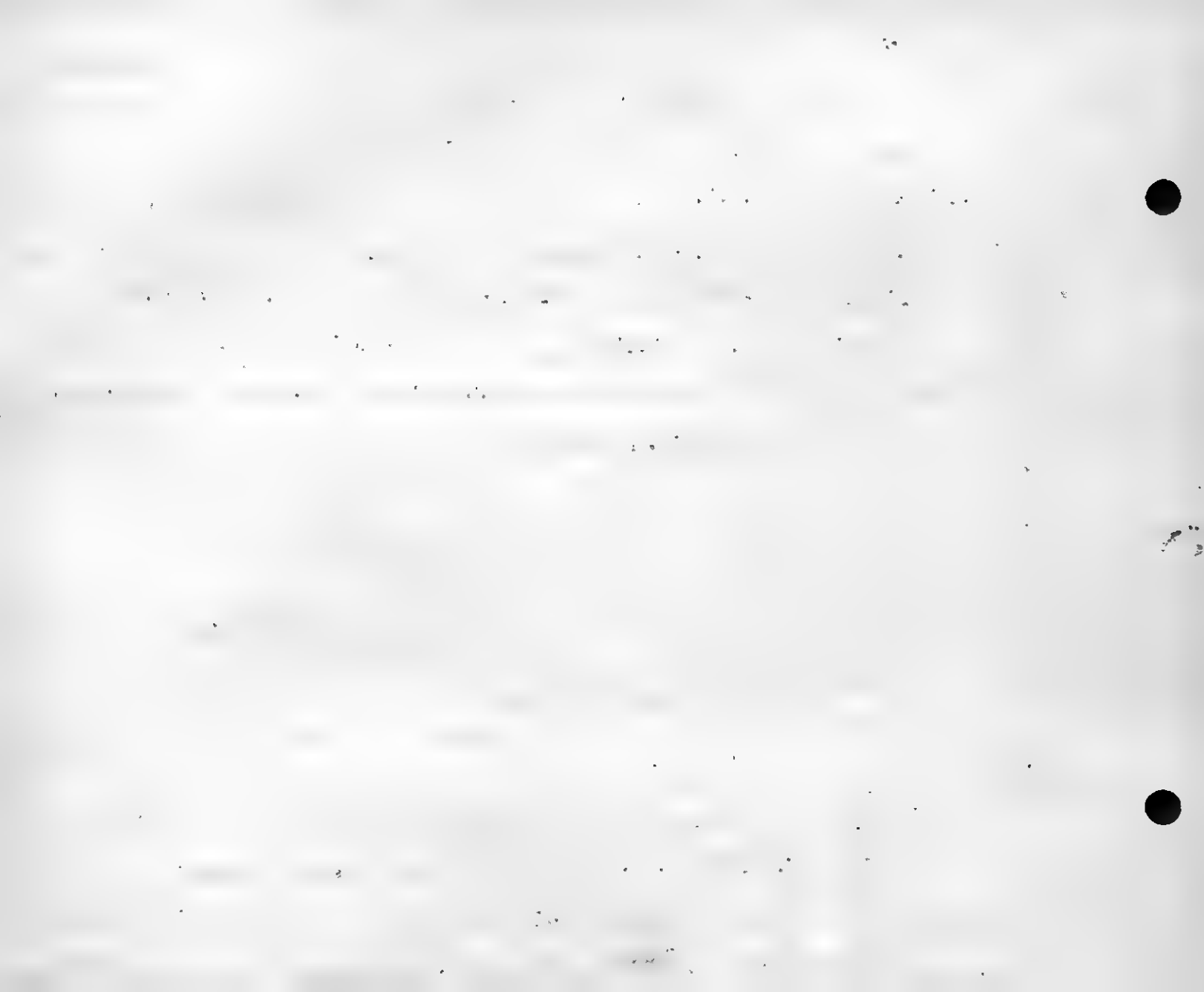


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SHIPPED TO: DAVISON FUNERAL HOME, LEXINGTON, NORTH CAROLINA

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <b>JOHN HAYDEN WILSON</b>						2a DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>68</b> 2b HOUR <b>12:45 PM</b>					
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6/29/10</b>		6. AGE (in years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign) <b>SOUTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY,</b> Md					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>GUARD</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>MIDDLE RIVER</b>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>15 W. Hickam Road</b>	
14. FATHER'S NAME First Middle Last <b>JOHN C. WILSON</b>				15. MOTHER'S M.A.DEN NAME First Middle Last <b>MINNIE L. HAYDEN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>YES</b> (If yes give year or dates of service) <b>WW II</b>				16b. SOCIAL SECURITY NO <b>241 01 74 20</b>		17 INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>4017</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO AUTOPSY</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that <b>(I)</b> (this hospital) attended the deceased from <b>9/29/68</b> , 19____, to <b>10/15/68</b> , 19____, that <b>(I)</b> (we) last saw the deceased alive on <b>10/15/68</b> , 19____, and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Peter N. Juvan</i>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/15/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>PETER N. JUVAN, M. D.</b>						22e ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/19/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>LEXINGTON CITY CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>LEXINGTON, NORTH CAROLINA</b>					
24. FUNERAL DIRECTOR <i>Joseph T. Zannino</i>						25a REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

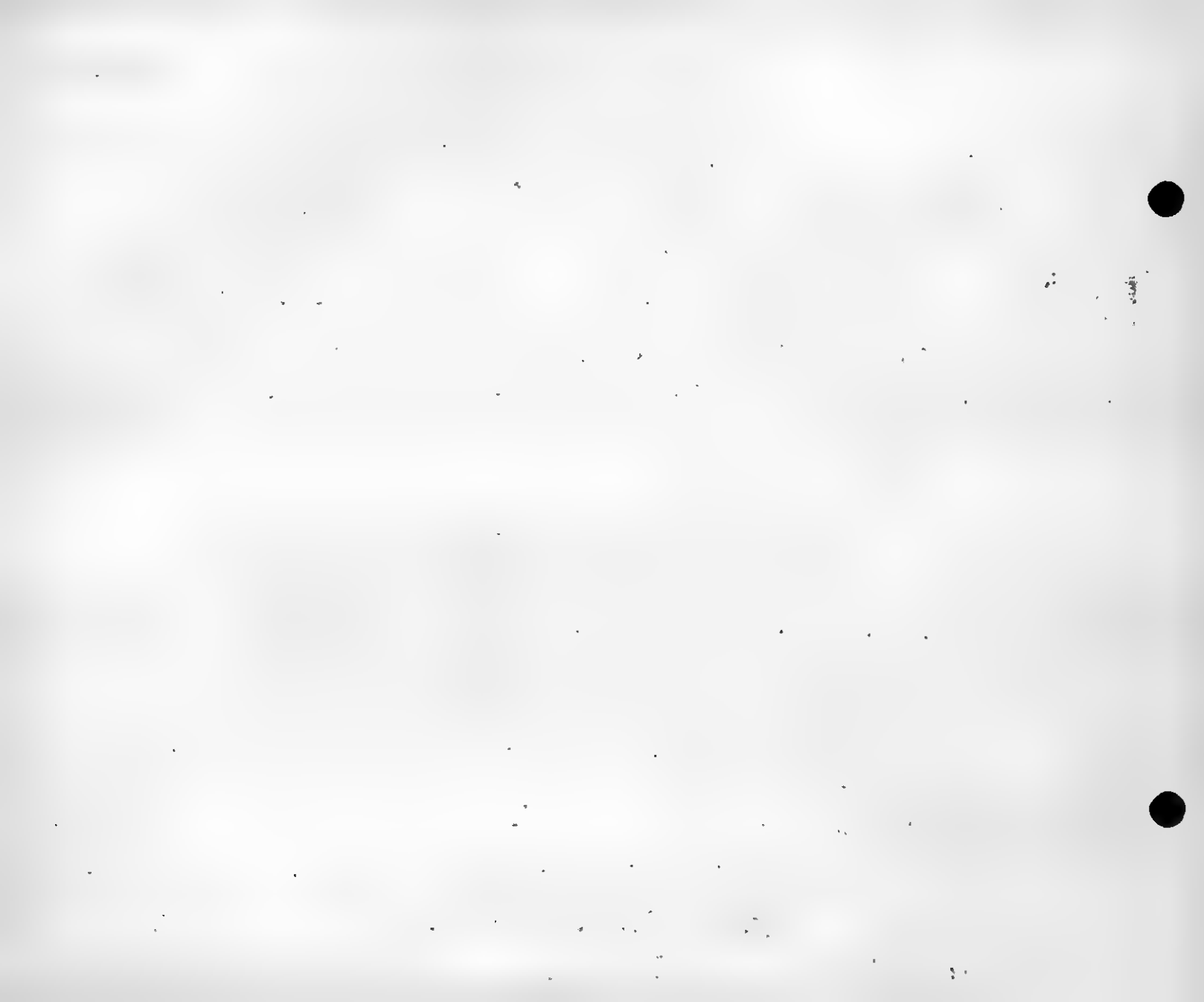
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1510M  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Mary E. Winkler</u>			2a. DATE OF DEATH <u>Oct 19 1968</u>		2b. HOUR <u>7:15 PM</u>
3 SEX <u>Female</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>Sept 1, 1890</u>	6 AGE (In years last birthday) <u>73</u> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Newport News, Va.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Baltimore</u> Md.		
10. CITY OR TOWN OF DEATH <u>Overlea</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>3911 Overlea Ave</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		
13a. USUAL RESIDENCE (Where deceased lived, if at institution. Residence before admission) STATE <u>Maryland</u>	13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Overlea</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>3911 Overlea Ave.</u>	
14. FATHER'S NAME First <u>Wolfgang</u> Middle <u>-</u> Last <u>Schoenberger</u>	15. MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Meyer</u> Last <u></u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <u>212-01-2453B</u>	17. INFORMANT Address <u>Herman R. Winkler 3911 Overlea Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>1829</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of uterus with</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastasis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>1965</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>174</u>					
19a. DATE OF OPERATION <u>May 1965</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Adenocarcinoma uterus</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>52</u> , to <u>Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles M. Kerr MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>Oct 21, 68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Charles M. Kerr MD</u>		22e. ADDRESS <u>6801 Belair Rd Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 30, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>	23d. LOCATION (City or Town) <u>Frederick Ave Balto.</u>	(County) (State)	
24. FUNERAL DIRECTOR <u>Dippel Bros Inc.</u>	ADDRESS <u>7110 Belair Rd.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 22 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14173

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14182

1. DECEASED-NAME (Type or print) <b>Stephen Erick WISE</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>2:55 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3/28/66</b>		6. AGE (In years last birthday) <b>2</b> YRS.		7. IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dependent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Temple Hills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>5805 Old Temple Hill Road</b>	
14. FATHER'S NAME First Middle Last <b>Victor Henry Wise, Jr.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Betty Catherine Trail</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory INSufficiency, Atelectasis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Bronchitis &amp; mucous obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4 wks.</b> (b) <b>50 fX</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acute passive Congestion &amp; Pulmonary edema moderate.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>6/22</b> , 19 <b>67</b> , to <b>10/5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard A. Jones</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/7/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>		22e. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Owings Mills, Md.</b>			
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

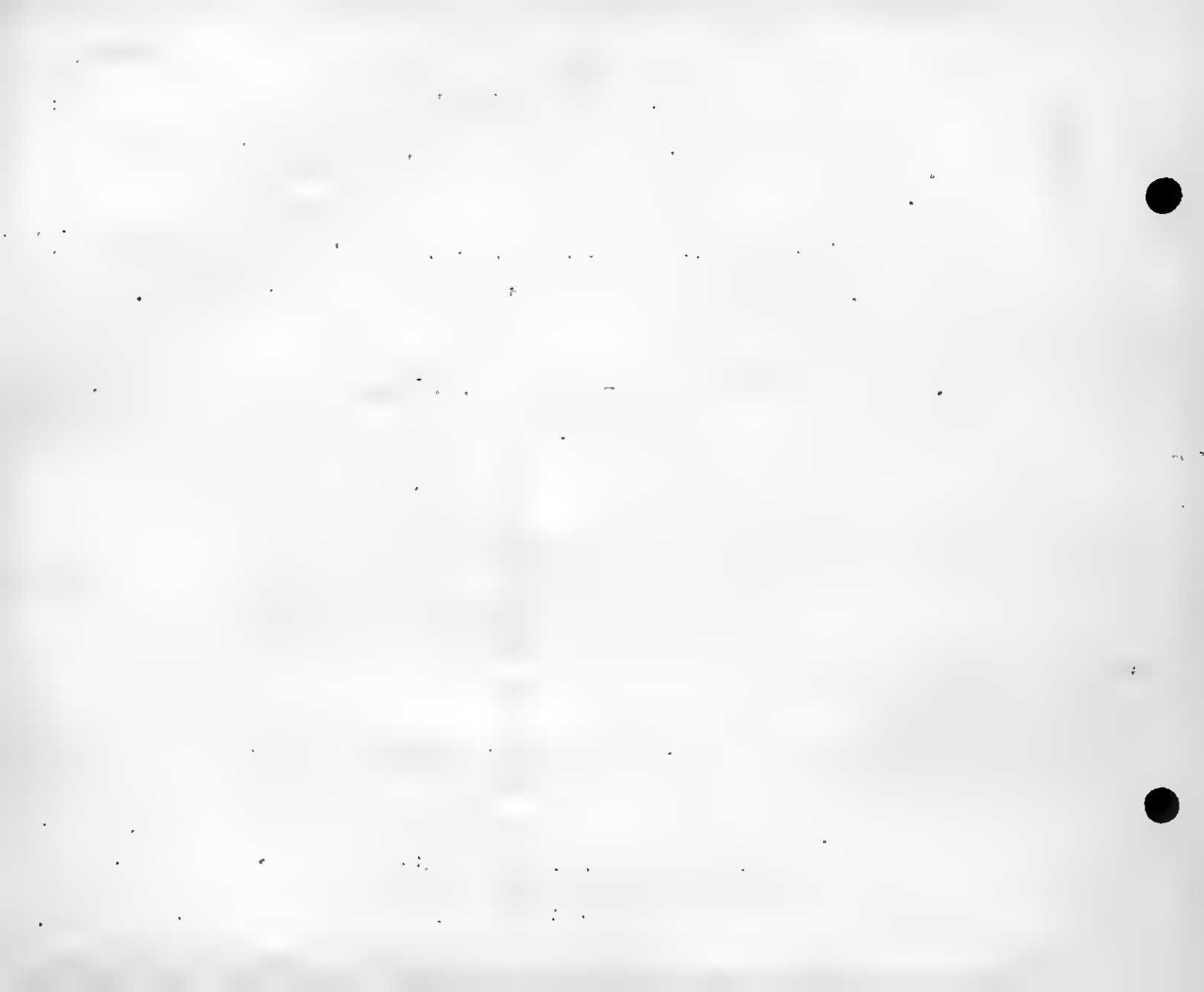
14176

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14183

1 DECEASED-NAME (Type or print) First MARY Middle F. Last YINGLING			2a. DATE OF DEATH 10 Month 30 Day 68 Year			2b. HOUR 11:50 P.M.	
3 SEX Female		4 RACE Cau.		5 DATE OF BIRTH May 10, 1910		6. AGE (In years lost birthday) 58 YRS.	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.	
7c BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.	
10 CITY OR TOWN OF DEATH Baltimore, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cen.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Welder		12b. KIND OF BUSINESS OR INDUSTRY Catalyst	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Walter Middle B. Last Shauck		15. MOTHER'S MAIDEN NAME First Catherine Middle Kirwin Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-07-5055	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-07-5055		17. INFORMANT Chas. E. Yingling		Address 721 W. 34th St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4107 Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 30, 1968, to Oct. 30, 1968, that (I) (we) lost saw the deceased alive on Oct. 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles C. Brown, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Oct. 31, 1968	
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.				22e. ADDRESS Greater Baltimore Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/4/68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		23d. LOCATION (City or Town) (County) (State) Howard County, Md.	
24. FUNERAL DIRECTOR Austin E. Donovan - 3818				ADDRESS Roland Ave.		25a. REC'D BY REGISTRAR DATE NOV 4 1968	
24. FUNERAL DIRECTOR Austin E. Donovan - 3818				ADDRESS Roland Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>William T. Young</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>68</b>			2b. HOUR <b>8 P. M.</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>9-13-1899</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>523 N. Potomac St.</b>	
14. FATHER'S NAME First Middle Last <b>George W. Young</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma M.</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>218-09-8760</b>		17. INFORMANT <b>Mrs. Mary Young</b>		Address <b>523 Potomac St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>9-29</b> , 19 <b>68</b> , to <b>10-9</b> , 19 <b>68</b> , that <b>10</b> (we) last saw the deceased alive on <b>10-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William T. Young</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/10/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>				22e. ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>10-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore City Maryland</b>			
24. FUNERAL DIRECTOR <b>Crach Funeral Homes 1211 Chesaco Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CHARLES</b>		First <b>A.</b>		Middle <b>ZANG</b>		Last		2a. DATE OF DEATH <b>October</b> Month <b>19</b> , Day <b>1968</b> Year				2b. HOUR <b>8 P. M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>June 13, 1912.</b>				6. AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md.							
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2802 Summit Avenue</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Steam Engineer</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2802 Summit Avenue</b>					
14. FATHER'S NAME First <b>Alfred</b> Middle <b>J.</b> Last <b>Zang</b>				15. MOTHER'S MAIDEN NAME First <b>Minnie</b> Middle <b>Edelman</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>213-10-9208</b>		17. INFORMANT <b>Mrs. Dorothy Zang</b>				Address <b>(Same)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesothelioma - Collagenosis</b> <b>228X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <b>229X</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1968</b> , to <b>10/19, 1968</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>10/19</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.													
22b. SIGNATURE <b>C. Herbert Mueller Jr</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/21/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>C. HERBERT MOELLER JR</b>		22e. ADDRESS <b>Parkton Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/23/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>				23d. LOCATION (City or Town) <b>Baltimore, Md.</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Oct 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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